TOWARDS A FAMILY AND COMMUNITY ORIENTED GENERAL PRACTITIONER :

The elusive goal of Medical Education in India

The Late Dr. Rangarajan Memorial Oration

By

Dr. Ravi Narayan
Community Health Adviser,
Community Health Cell
Society for Community Health Awareness, Research and Action,
Bangalore, - 560 034,
Karnataka
Tel: 080 – 553 15 18 Telefax : 080 – 552 5372
e-mail : sochara@vsnl.com

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Introduction

In 1972, a young doctor enthused by a three month experience of community practice in the East Pakistan refugee camps near Calcutta and other short community practice experiences in urban slums of Bangalore and some rural parts of Karnataka embarked on a post graduate thesis for his public health degree at the London School of Hygiene and Tropical Medicine, on the theme "Training Doctors for Community Health Services – trends in undergraduate Medical Education in India". After a whole year of review, of 25 years of medical literature and dialogue he arrived at seven principles to reorient Medical Education and make it more relevant to the country's needs (see Box 1).

Box 1

Training Doctors for Community Health Services

- University involvement in health care
- Improvement of standards of teaching and teachers
- Development of local knowledge and local technology, not just imports
- Appreciation of economy and effective utilization of available services
- **Greater emphasis on general practice and general practitioners**
- Continuous evaluation of curriculum and innovation
- Motivation of medical profession by better role models among teachers and elders

Source : Narayan, R., DTPH Dissertation, LSHTM, 1973

Significantly, one of the principles was greater emphasis and focus on General Practice. The dissertation suggested a three-point programme (see Box 2) if this emphasis was to be translated from rhetoric to reality.

Box 2

General Practice in Medical Education
A three point programme

- Introducing General Practice Units in hospital outpatients
- Involvement of General Practitioners in teaching / training programmes
- Starting General Practice department or speciality in every medical college.

Source : Narayan, R., DTPH Dissertation, LSHTM, 1973.

Today, 30 years later, after 12 years of being a faculty of a medical college with a mandate of social / community orientation and 18 years of a health policy researcher and a health activist with particular focus on medical education and health human power development, the same doctor stands before you today to reflect on this elusive goal.

If I was a cynic, I would have probably called this Oration **'General Practice in Medical Education : Devalued, Disregarded and Distorted'**, reflecting the reality of the last 50 years. However, being an unbounded optimist, I have chosen to call it 'Towards a family and community oriented General Practitioner' - the elusive goal of Medical Education in India – to share a vision of a future. I think it is particularly significant that I give this oration in Forum 2002 that seeks to reach and support the busy but effective family physician. Even more significant that I do it at the Sundaram Medical Foundation, an institution nurtured by the late Dr. S. Rangarajan with a vision and mandate to provide quality medical care to the community that is effective, affordable, appropriate and regularly audited for quality and relevance.
I thank Dr. Arjun and the faculty of the SMF for this honour and privilege.

1. Goals of Medical Education

Medical Education and its social and community orientation has been a subject for discussion and dialogue in India especially since the Bhore Committee report of 1946 and continues to be an area of concern, included in the draft National Health Policy of 2001.

What is the type of doctor we in India have wanted to produce?

The Bhore Committee, 1946

"The physician of tomorrow.... will be scientist and social worker; ready to cooperate in team work: in close touch with the people he disinterestedly serves, a friend and leader he directs all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down, the social physician, protecting the people and guiding them to a healthier and happier life.

The Mudaliar Committee Report, 1961

"Medical education should fit in with the needs of a country..... India being more than 80% rural, the training given to a doctor should enable him to carry on his work among the vast masses in the villages".

The Patel Committee, 1970

The Basic Doctor is one who is well conversant with the day to day health problems of the rural and urban communities and who is able to play an effective role in the curative and preventive aspects of the regional and national health problems besides being fully well up in clinical methods....., he should have the competence to judge which cases are required to be referred to a hospital or a specialist. He should be able to give immediate life saving aid in all acute emergencies. He should be capable of constant advancement in his knowledge by learning things for himself by having imbibed the proper spirit and having learned the proper techniques for this purpose during his medical course".

The Srivastava Report, 1975

"The most important is the training of the general medical practitioner who occupies a central place among the different functionaries needed for the health services. His work is not merely with treatment of sickness and prevention of disease but also with those social and cultural problems that contribute to the fabric of health. His commitment is to man and to the human family. He must change his outlook from an excessive concern with disease to a role of full social responsibility"

The WHO – SEARO ROME report, 1988

"The graduate doctor... responsive to social and societal needs and who possess the appropriate, ethical, social, technical, scientific and management abilities to enable them to work effectively in the comprehensive health system based on primary health care.....".

The Bajaj Committee Report, 1989

"A basic doctor, to effectively delivery health care to the country, must be an astute clinician, a good communicator and educator and a sound administrator, so as to effectively lead an ever-expanding health team for a positive health action work. The action domain of the doctor has crossed the boundaries of drugs and dispensaries and presently extends to a large extent to the families and to the communities – hence the need for the basic doctor to be a community physician.."

The medico friend circle, alternative curriculum, 1991

Community oriented, socially conscious, primary health care provider.....with competence and capability..... multidisciplinary skills, knowledge and attitudes far beyond conventional medical boundaries.

MCI Recommendation, 1995

"Graduate medical curriculum is oriented towards training students to undertake the responsibilities of a physician of first contact who is capable of looking after the preventive, promotive, curative and rehabilitative aspect of medicine....".

To summarise these goals, the overall goal of medical education in India is to produce doctor with the qualities and capacities shown in Box 3

Box 3

Goals of Medical Education
(from Bhore (1946) to draft NHP 2001)

- the basic doctor;
- community orientation;
- family orientation
- general medical practitioner
- primary health care provider
- social physician
- astute clinician
- good communicator / educator
- sound administrator
- community physician

2. Initiatives Towards Reaching this Goal

In 1992, my colleagues and I undertook the first serious study to document descriptively and analytically all the experiments and innovations in the country towards these goals. The study included an extensive literature review; a survey that identified 30 out of 125 medical colleges that were doing something to reach these goals; a survey of medical graduates with work experience in peripheral health institutions; and field visits and interactive dialogue in six key community oriented medical colleges in the country. Of the 50 innovations, we identified and studied, a few specifically relevant to the goal of producing community oriented and family oriented general practitioners are outlined. These were :

Box 4

Initiatives for Reorientation – I

1. Community based orientation camps in first, third and final years
2. Reorienting pharmacology to rational therapeutics, essential drugs concept and clinical orientation
3. Community based family care programme
4. Special training programmes in
   - **Health education**
   - **Management**
   - **Health Economics**
   - **Epidemiology**
   - **Ethics**
   - **Nursing**
5. Rural / urban slum health visits / camps
6. **Curative – preventive General Practice Unit (CPGP)**

Source : Strategies for Social Relevance, CHC, 1993.

Box 5

Initiatives for Reorientation – II

7. Training in
    a. Emergency medicine
    b. Social paediatrics
    c. Social obstetrics

8. ROME Scheme – mobile hospital scheme

9. Posting to government PHCs and sub-centres

10. Involvement of interns in special field situations
    a. Epidemic control
    b. Disaster relief
    c. Plantations
    d. NGO health and development projects
    e. Immunization programme
    f. Family planning motivation

11. Internship training in specific additional skill
    a. Rational drug use
    b. Management
    c. Ethics
    d. Health education
    e. Epidemiological projects
    f. Clinical research

12. Internship training in GOPD (General Practice Unit)

Source : Strategies for Social Relevance, CHC, 1993.

While taken together they represent quite a significant collection of innovations. However, the reality was that just a handful of colleges were seriously involved in these types of innovation. Most others conducted a didactic, unimaginative, orthodox medical education that was caught up in

- the dialectics of the needs of primary health care versus the glamour and demand of secondary / tertiary health care.
- the established middle class culture of education
- the changing commercial values of students and teachers
- the large urban, specialist aspirations in future vocations
- the infectious enthusiasm for high tech advances in medicine, the super-specialist ethos of medical care and the need to keep up with western models and orientation

Not surprisingly the quest for post-graduation / specialisation was high. The quest for general practice and family medicine low.

3. General practice related innovation

Surprisingly the only two innovation out of fifty identified had a direct relevance to general practice was the CPGP unit of Baroda Medical College and the GOPD unit of MGIMS, Sevagram. What were these initiatives?

a. The CPGP Unit of Medical College, Baroda

This is an integrated curative and preventive unit with a small lab attached that is located in the OPD of the teaching hospital and acts as a point of filtration and referral for patients.

A team of staff pooled from clinical departments and staff of PSM department along with interns run this unit. All patients who attend hospital OPD are seen by this unit and managed as far as possible within the facilities of the unit unless they need specialist referral. Emphasis on proper documentation and on the preventive and social aspects of illness and follow up home visits of patients help to give students and interns an orientation to general practice and family medicine.

b. GOPD of MGIMS (Mahatma Gandhi Institute of Medical Sciences) Sevagram

The GOPD is a replica of a primary healthy centre but is run as part of a teaching hospital to inculcate in students and interns the idea and challenges of family medical practice. The GOPD consists of 7 complementary clinics – a MCH clinic; an immunization clinic; a TB clinic; a leprosy clinic; a nutrition clinic; a mental health clinic; a health education cell and a side laboratory. It focusses on teaching students and interns how to diagnose cases clinically, epidemiologically, socially and how to advise total management.

While both these units were relevant to giving students a general practice / family orientation they did not involve local GPs and had became marginalised adjuncts in the medical college where the rest of the departments continued there 'east coast of USA medicine – business as usual'. In Baroda, the innovation wound up with change of leadership. In Wardha, it has continued but lost some of its original spirit.

c. Continuing Medical Education for GPs – the CMC-Vellore initiative

The CME programme for General Practitioners started in the late 1980s by CMC-Vellore is a good example of what can be done by a medical college. The focus has not only been on updating the knowledge of GPs by self learning modules but the CME programme has also covered ethics, management and other issues to improve practice. Much more can be done but this was an excellent beginning.

Box 6

'The General practice unit'
(Posting of students / interns)

1. CPGP, Baroda

- Integrated curative and preventive unit
- OPD of teaching hospital with small lab attached
- All patients seen. Referred to specialists only if really necessary
- Staff pooled from clinical departments and PSM
- Emphasis on preventive and social aspects and good records
- Home visits if required

2. GOPD – Sevagram

- 'Replica of PHC in OPD of teaching hospital
- Orientation to family medical practice
- Seven complementary clinics – MCH, Immunization, TB, Leprosy, Nutrition, Mental Health, Health Education
- Emphasis on clinical, epidemiological and social factors
- Training for total management

Source : Strategies for Social Relevance, CHC, 1993

5. Graduate Feedback

50 young graduates who had experience of peripheral health institutions and who were identified in entrance examinations for post-graduate course in South India, helped us to get relevant and realistic feedback on what was crucially required if medical education experience had to prepare young doctors for the challenges of practice, independent decision making, and the physicians of first contact care.

- ❖ Practical skill orientation during clinical postings including venesection, lumbar puncture, minor surgical procedures, etc.
- ❖ Need to develop reliable clinical skills not too dependent on high tech diagnostics
- ❖ Need to integrate community, family, preventive and rehabilitative aspects in clinical training
- ❖ Need for training in medical ethics; alternate systems of medicine; basic nursing procedures; communication skills; basics of management / administration; leadership and training skills; counselling and other non-drug therapies.

While qualitatively this graduate survey – the only one of its type in the country in 50 years was valuable in generating ideas supportive of change i.e., responsive to grassroots experience, we had cautioned in our report that a more comprehensive feedback should be facilitated including larger number of general practitioners from small towns and villages and medical officer of primary health centres. Such a survey has not yet taken place.

6. What has gone wrong?

We see therefore that while the goals of medical education in India has been stated to be towards the basic doctor – a community and family oriented general practitioners: and there has been some efforts towards this by a few colleges through innovations and initiatives in the training programme, including two initiatives focussed on general practice and family medicine itself, by and large the overall trends have been surprisingly consistent and in the opposite direction.

The Srivastava report of 1974 sums it up aptly....

Box 7

Situation Analysis of the 1970s

- "The strangle hold of the inherited system of medical education
- The exclusive orientation towards the teaching hospital
- The increasing trend towards specialisation and acquisition of post-graduate degrees
- The lack of incentives and adequate recognition for work within communities (including general practice)
- The attraction of the export market for medical manpower

These are factors responsible for the aloofness of medicine from the basic health needs of the people"

Source : Srivastava Report, 1974

Is the situation any different in 2002 A.D.?

While all these factors are still relevant today, I would like to suggest another list of factors that look at this problem from a different angle particularly in the context of the growing paradox in the country.

It needs urgently general practitioners and family physicians and is getting mostly doctors preoccupied with high tech secondary and tertiary care increasingly commercialised, bio-medicalised, and irrelevant to the social-economic-political-cultural realities of the large majority of our people.

Medicine as a social service and a vocation is fast developing into medical business with a profit motive. What has gone wrong? Unlike the Srivastava report which was a polite professional assessment, I believe the time has come to be incisive. The 'professional conspiracy of silence' has to give way to accepting evidence as reality.

We cannot be part of a solution if we do not first realise we are still part of the problem.

What are these factors?

a. The devaluation of General Practice in Medical Colleges

In most medical colleges, with the over emphasis of the teaching hospital as a base for clinical training, there is a subtle devaluation of general practice in the minds of the young doctors. Clinicians often go out of their way to exaggerate the incompetence of a GP or family physician when a referral case is seen with complications or otherwise. Rather than endorsing the fact that for every complicated referral there are hundreds of routine cases that are being managed by the busy GP, the young medico is made aware of the incompetence or ineffectivity of the GP's role.

b. The cultural colonialism of Medicine

Even though nearly six decades have passed since we achieved independence, the colonial mentality of the medical profession, the elite bureaucracy and the political leadership have not disappeared. What is 'west is best'! Still rules the medical mind. The craze for foreign degrees, foreign linkages and 'east cost of USA medicine' foreign technology and foreign medical culture has increased. The brown sahebs who rule India have deep roots in their background and education which make them see dictates of western society as more important than basic needs and aspirations of our people. ***Neem, turmeric, yoga, meditation find respectability only when they are endorsed by the west. When will this end?***

c. The commercialisation of medical practice

Over the years, medical practice has been increasingly commercialised. The commercialisation has included the mushrooming of private health care institutions; the growth of high technology diagnostic centres; the concurrent glorification of high technology through high pressure advertising in the media; the problem of private practice among full time teachers of medical colleges; the 'increasing doctor-drug producer axis' and the growing vested interested in the 'abundance of ill health'; the increasing spread of kick backs, cut practice and now even cut throat practice!

d. The 'cancer' of Capitation Fees Medical College
Commercialisation beyond privatisation

One of the 'concerns' of medical education is the mushrooming of capitation fee colleges based on caste, communal and political affiliations. No amount of name changing to 'self financing', private etc., will make any change in their questionable respectability. There is growing evidence how they have used their lobby to corrupt the exam systems, promote the fall in standards; and use their money power and political influence to affect admissions, appointments, results. The nexus between capitation fees lobby and the political system are well established.

e. The inadequacy of present day Continuing Medical Education

Most continuing education for practitioners is mostly content education or, technical information transfer focussing on content, seldom on process or context. There are numerous CME selling products and technologies. Hardly any on improving the standards of medical practice or improving cost consciousness, effectivity and efficiency in general practice; or promoting quality assurance, or enhancing, ethical, social, epidemiological, management or communication capacities.

f. The pseudosocialism of our political and professional leadership

The political leadership and the leaders of the medical profession have found it in the interest of the elite and privileged sections of the community to promote the social goals of medical education as political and populist rhetoric. However, in actual practice they have neglected primary health care and promoted secondary and tertiary care in urban areas with highly sophisticated technology that has served their own class. All this through heavy subsidy by the government in the name of the people. Now with the neo-liberal economics even this populist rhetoric is being jettisoned; with more and more of the leadership seeking medical care in centres of excellence abroad. In the new draft NHP 2001 even this pretence is dropped and the policy makers want to convert India into the Mecca of modern medicine promoting medical tourism and further commercialisation.

g. The distorted expectations of the citizens

By the constant education of the profession, media and leadership, the citizens of the country are also opting for more and more medicine; demanding injection, tonic and high tech diagnostics; and completely ignoring our own long standing folk health traditions that have stood the test of time. ***Rice kanji is giving way to electral; non-drug traditions of yoga and meditation are giving way to costly adjuncts to therapy.***

h. The complex pathology of present day medical college leadership

Our national study identified 12 pathologies of present day leadership. I am sure to many of you this would be very familiar.

Mental Disorientation	Confusion between excellence / relevance
Nystagmus	Continuous shift between tertiary and primary care
Optic Atrophy	Reduced field of vision / orientation
Anemia	weak individualistic selective responses
Cancer	Effect of market value and promoting commercialisation
Manic Depressive Psychosis	Too much planning too little follow up
Atopy	Allergy of students to badly planned programmes
Arteriosclerosis	Routinization affecting creativity
Schizophrenia	Clinical / community dialectics
Graft rejection	Unsuccessful transplants of foreign ideas
Autism	Staff withdrawal due to cynicism
Senile dementia	Status quo / lack of openness to change

In this multidimensional pathology, little change or reorientation can be nurtured.

i. Corruption in Medical Education and Society

Corruption has become the bane of public and private life in India and has crept into all sectors of development and human endeavour. Medical education is no exception. Influence of money power and power politics in the selection of candidates for admissions; selection of teachers for appointments; modifying examination results; extraneous influences on promotions, transfers, research and training grants and the concerns growth of private practice ethos in patient care within government hospitals and health care services are all manifestations of this problem. Recently, as a policy researchers, I helped the Karnataka Government Task Force in Health and Family Welfare explore this new public health challenge. Two examples of reality quoted in the Task Force Report should shock us out of our professional smugness:

- ***Junior doctors testified that the large majority pay charges to examiners at designated centres to prevent being failed!***
- ***In a corporation maternity centre, the charge to see a newborn baby is Rs. 500/- if male and less if female!***

Where is medical education and health care heading?

j. Too much diagnosis : too little treatment

The rhetoric for reform and reorientation has gone on too long. Much of the literature on medical education has been filled with what is wrong - case of over diagnosis and under treatment. Small efforts and innovations are ignored or poorly documented. Innovations are hardly subjected to evidence based evaluations, peer review or any objective analysis. There is need to change this. Teachers and students must demand change. Patients and citizens must exert social pressure. Health is both a right and a responsibility.

7. The Way Ahead – Challenges and Options

What can we all do to reverse these trends and to bring back medical education on track and focus it specially towards general practice and family medicine?

a. Bring 'Ethics' back into the Health Profession

This is an urgent imperative if the people are not to lose faith and respect for what, till has recently been considered a noble / social vocation. Prof. Madhav Menon of the National Law School University of India has suggested that this 'Back to Ethics' movement must have five principles

- Profession for the people (not profits)
- Respect for patient autonomy and human rights
- Duty to protect life and reduce suffering
  (no financial exploitation, emotional exploitation, sexual exploitation, etc.)
- Duty to act fairly
  (Hallmark of civilised society and objective of all the laws and regulations that govern us)
- Professional accountability.

Two significant initiatives in this direction have been

i. The Rajiv Gandhi University of Health Sciences in Karnataka is the first university in the country to introduce Medical Ethics as a separate curriculum subject in all the Medical Colleges under its jurisdiction.

Box 10

Ethics Course

"Doctors and other health professionals are confronted with many ethics issues and problems with advances in science and technology. These problems are on the increase. It is necessary for every doctor to be aware of these problems. The doctor should be trained to analyse the ethical problems as they arise and deal with them in an acceptable manner. It is therefore recommended that teaching of Medical Ethics be introduced in Phase I and continued throughout the course including the internship period".

RGUHS ordinance, 1997-98

ii. Some ethical doctors in Mumbai have set up the Forum for Medical Ethics and bring out a regular bulletin called Issues in Medical Ethics that is for the first time raising a host of issues for debate and critical reflection within the profession. (sandhya@medicalethicsindia.org ; subscribe@medicalethicsindia.org

b. Bring 'General Practice' and 'Family Medicine' to the core of Medical Education, Medical Care and Health Services

The focus must change from specialists and secondary / tertiary care centres in urban areas back to the 'central' role and need for good 'general practitioners' and 'Family Physician' – a group that has been ignored, disregarded, neglected for too long.

It is time that GPs / Family Physicians are seen as major contributors to Health Care. as the face and heart of the profession.

I personally believe that to be a good ethical GP or family physician. socially relevant and community and family oriented today is far more specialised task – with its own multidisciplinary capacity and challenge. The cardio-thoracic surgeon and the neurosurgeon pale into insignificance as 'glorified technicians' in comparison.

Box 11

The low skill – high skill shift
(GPs and Family Physicians)

The community oriented, Primary Health Care doctor is by no means a 'basic', second rate, or low-skill doctor as is made out by the protagonists of the conventional curriculum. She/He needs greater competence and capability to work in the community and has to develop multidisciplinary skills, knowledge and attitudes far beyond conventional medical boundaries. Her/His specialist colleague, while certainly being necessary for delivering highly technical medical services has the disadvantage that she/he can function only at secondary and tertiary levels with an array of infrastructural and technological and senior peer group support. But in the present system, she/he is at best a glorified technician. This shift of emphasis is basic to the development of the community oriented doctor.

Source : mfc anthology 1991

Four (4) concrete steps can be taken to do this

i. ***GPs and Family Physicians should be made role models for young doctors by inviting them to teach, share experiences and challenges during the medical course.***

ii. ***GPs and Family Physicians should be given linkages to Medical Colleges as teachers / visiting faculty.***

iii. ***GPs and Family Physicians should be linked to government hospitals, private hospitals as frontline extensions for home/family/community care and follow up.***

iv. ***Medical Colleges, professional associations must organise Continuing Medical Education that go far beyond information transfer on the latest in medicine to building up skills and capacities required for improving the standards, quality, scope and framework of general practice, family practice in the community.***
These will include at least four to being with

- ***Ethics***
- ***Management***
- ***Communication and***
- ***Alternative systems***

The first to humanise the profession; the second to make it more efficient and cost and quality conscious; the third to help it build patient autonomy and rights; the fourth to locate it in the rich plural traditions of the country and help to give the patient and his family the best options for care.

c. ***To generate competence in evidence based Rational Medicine and Health Care***

It is not just a question of 'ethics' and respectability. What is needed urgently is also good science and if one looks around what has changed in recent years is not just the ethics of the medical profession, but a lot of what we do is 'unscientific' and 'irrational'.

These fall into three major technical categories

i. Irrational Diagnosis
ii. Irrational Treatment practices
iii. 'Ritual Mutilations' or unnecessary surgeries

Each of these is a subject by itself but we need to look at them seriously, undertake action research studies; peer review; evidence-based reviews; and evolve counter strategies. Some examples:

- Why is the rate of caesarean sections going up?
  (40% of lower middle class women in a SMF survey!)
- Why are 'injections; and 'tonics' and 'saline' becoming the sheet anchor of general practice?
- Why are CT scans and MRIs becoming big business suddenly?
- Why are we continuing to dispose medical wastes irrationally?
- Why are antibiotics being misused, over used, abused in the country?

The list of questions for which evidence is required is endless!

What can we all do about it? Can we have better recording / reporting mechanisms to enhance the data for such decision making. Can more MD Thesis and dissertations look at these issues? Can centres such as SMF do more action research studies with a network of GPs and family physicians to gather evidence on these trends?

We all need to network and tackle this problem and generate a new movement for Evidence based Medicine and Health Care?

d. ***Promote 'civic society' participation in Medical and Health policy – The Peoples Health Movement factor***

For too long the Medical Profession and the Medical Education sector have been directed by professional control and debate. It is time to recognise the role of the community, the consumer, the patient, and the people in the whole debate. Bringing Medical Service under the preview of the Consumer Protection Act has been the first of the required changes. Promoting public debate, review and scrutiny into the planning dialogue for reform or reorientation has to be the next step. This could be brought about by the involvement of peoples / consumers representatives at all levels of the system – be it service, training or research sectors. However all these steps can never be brought about by a top down process. What is needed is a strong countervailing movement initiated by health and development activist, consumer and people's organisations that will bring health care and medical education and their right orientation high on the political agenda of the country.

The whole mobilization that 18 National Networks did last year for the Jana Swasthya Sabha (the first National Peoples Health Assembly) in Kolkata, December 2000 and the global Peoples Health Assembly was in this direction.

Significantly, one of the 5 booklet that emerged as a consensus document was entitled **'Confronting the Commercialisation of Health Care'**, which brought a peoples' perspectives on Rational Medical Care, Private health sector in India, Medical Ethics, Medical Education and Health Care in India. Now translated into all the Indian languages it has started the peoples dialogue on these issues which is long overdue. The final page of this booklet is significant to this reflection.

PHA and Health Care

The focus of the Peoples Health Assembly is on

- Recommendations to Government and professional bodies on measures – legal and administrative needed to check this commercialisation and keep medical practice effective, safe, cheap and holistic.
- On peoples initiatives and mass mobilization to educate the people on their rights, help them with strategies to cope individually and as communities with the problems due to commercialisation of health care and to build up public awareness for reform of the medical sector.

All those concerned about Peoples Health needs and Peoples Health will have to take on this emerging challenge as we begin the new millennium. Our efforts will determine whether in the years to come, health care and medical education will primarily respond to the peoples health needs and aspirations or will professional expectations and market phenomena continue to distort the process.

MARKET or PEOPLE? What will be our choice?

Source : PHA Booklet - 5

e. Recognising and Promoting the Paradigm Shift

Finally, the greatest challenge to all of us health care providers – at whatever level we may be and particularly for general practitioners, family physicians, PHC doctors, community health doctors and to health policy makers and opinion leaders of the health professions at all levels is the urgent need to recognise the 'paradigm shift' required if 'Health for All' has to become a reality any time in the future.

We have been promoting this new paradigm for over 15 years since we see this as the only way we can move ahead.

First we must move our focus from individuals to family and community in all that we do.

Secondly, we must move beyond the biomedical and physical dimension to explore the psychosocial, economic, cultural, political and ecological dimensions of every health problem we tackle (including stigma, poverty, social burden).

Thirdly, we must move away from our preoccupation with drugs and vaccines to education and social processes and non-drug therapies including life style change as the focus of our efforts.

Fourthly, our health care providing should move away from dependency creation and mystification and professional control to greater enabling, empowering and autonomy building among our patients and the people we serve.

Fifthly, our attitude to patients should move away from considering them as passive beneficiaries to active participant of all our services and our programmes.

Finally, our research efforts must move beyond orthodox molecular biology and pharmaco therapeutics to socio-epidemiology and behavioural sciences.

In this new health revolution – the new movement towards a more relevant paradigm of health and health care, ***general practitioners and family physicians will become the centre of the process – the core of the health care services since they are best suited, most capable and best located in the health care – community continuum to herald this new thinking, this new value, this new paradigm.***

Specialists experts, those who are compartmentalised by their training of knowing more and more about less and less will then have to move to the margins of this new health care revolution.

A time has come to make this paradigm shift from specialist care to family practice.

ARE WE READY FOR THIS CHALLENGE?

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