National Consultation on Family Medicine Programme

Report and Recommendations

Convened by:
National Health System Resource Centre
National Rural Health Mission
Ministry of Health of Family Welfare,
Government of India

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EXECUTIVE SUMMARY

The importance of Family Physicians as providers of a comprehensive primary care is a very significant development required for India's progress towards Universal Health Care. The second phase of NRHM and the goals set by 12th plan for India have also kept primary care as its central agenda. India is now all the more willing to learn from its own experience and international success stories in this regard. The development of a comprehensive Family Medicine programme for India is a key intervention required for its success.

The increasing demand for specialists and super specialists has marginalized the policy directions in the health policy 2002 to strengthen the Family Medicine programme in India. Lack of recognition of these courses by the statutory bodies, especially Medical Council of India, has contributed to this weakness as well. The National Rural Health Mission (NRHM) supported a Post Graduate Diploma programme in Family Medicine (PGDFM), and is offering support to doctors working with public health institutions, especially from the high focus states of India. However, the scale has not been significant to impact change. The programme run by National Board of Examination has also not yet been recognized as a specialization in either Government appointments or in teaching institutions.

Strengthening the Family Medicine programme in India requires a multi-pronged approach. The National Consultation on Family Medicine was an effort to bring all the current isolated experiences from various parts of India, and the stakeholders entrusted with licensing, and policy makers together to deliberate on 5 key themes; Skills requirement of a Family Medicine doctor /

Nurse at secondary care level; Family Medicine in undergraduate curriculum; Family Medicine in postgraduate curriculum; Family Medicine in Nursing, and Governance and Regulatory issues in Family Medicine. The consultation also reviewed and learnt from the inspiring experiences of family medicine and primary care practitioners from across the world. A special session also explored how the learnings will be able to address the challenges relating to family medicine practice in India.

The consultation made recommendations for all major stakeholders; Medical Council of India (MCI), Nursing Council of India (NCI), National Board of Examination (NBE), Central & State governments and Universities in India.

The consultation was held as part of the 1st National Conference on Family Medicine & Primary Care, at New Delhi.

INTRODUCTION

National Health Systems Resource Centre[1] (NHSRC) have been facilitating a distance learning programme for creating Family Physicians who can 'resolve more and refer less' when posted at peripheral public health institutions. The Public Health Administration team of NHSRC worked with Christian Medical College, Vellore and developed a curriculum (in 2008-09) for the National Rural Health Mission (NRHM) supported Post Graduate Diploma in Family Medicine (PGDFM) programme, which is offered through distance learning. Further the team visited all high focus states (in 2009-10) for identifying training sites and to sensitize the leadership of the NRHM programme in the states for sponsoring candidates for the PGDFM programme. The programme which is of 2 years duration has 30 days contact sessions and monthly video conferencing held at district level. Post training, faculty from CMC Vellore also makes 'supportive supervisory' visits to ensure practice of protocols by the students. So far two batches have undergone training from the high focus states.

In addition to supporting the PGDFM pilot programme, the expert group pursued with MGR University, Chennai[2] for the introduction of a 3 year MD programme in Family Medicine incorporating surgical skills. This approach was keeping in mind the positioning of a FM doctor as a specialist at the CHC level who will manage, along with his team, a set of comprehensive services including minor surgeries, chronic diseases management, C-sections, blood transfusions etc.

For scaling up these initiatives, the expert group collaborated with the AFPI, the Academy of Family Physicians of India and organised a National Consultation on Family Medicine in April, 2013.

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[1] *A technical support body to Ministry of Health & Family Welfare created under the National rural Health Mission*
[2] *Capital of the state of Tamil Nadu in India*

Objectives of the National Consultation

(a) To review and share experiences of family medicine and primary care practitioners from across the world related to Public health practice

(b) To identify issues and challenges relating to family medicine practice in India

(c) To explore the possibilities of developing a Family Medicine programme in Nursing

(d) To make specific recommendations to stakeholders / gate keepers on Family Medicine practice

Themes of the National Consultation

(a) Skills requirement of a Family Medicine doctor / Nurse at secondary care level

(b) Family Medicine in undergraduate curriculum

(c) Family Medicine in postgraduate curriculum

(d) Family Medicine in Nursing

(e) Governance and regulatory issues in Family Medicine

INAUGURAL MESSAGES

The Inauguration of the National Consultation on Family Medicine (and the Conference on Family Medicine & Primary Care) was conducted by Sh. Keshava Desiraju, Union Health Secretary, MoHFW, GOI. In the inaugural address he took note of the differential situation of health status & health system development in the states and emphasized on the role of state in providing Universal Health Care. He also emphasized on the issue of the Family Medicine programme getting accredited by the Medical Council of India.

The guest of honour was Prof. Michael Kidd President Elect, WONCA. He stressed in his speech on the importance of having 'social responsibilities' in addition to professional responsibilities by the Family Medicine professionals. He said that countries have passed through the phase India is passing through now and that in many places Family Medicine practice has been able to make significant change.

The key note address was delivered by Prof. Srinath Reddy, President, PHFI who spoke on'Family medicine in the context of Universal Health Coverage'. He emphasized on the importance of identifying the right institutions for training of Family Medicine programmes, and that these institutions should ideally be located in rural settings. He also said that public health institutions like the District hospital can be recognized as training centres by the National Board of Examination which is currently conducting Family Medicine programmes in India.

Dr. Purushotam Lal, Member, Board of Governors, Medical Council of India spoke on 'Family Medicine: Where we were, where we are!'. He recalled the challenges faced by the Family Medicine practitioners in the era of 'super specialists' in India. He also suggested that a bond system can be put in place if government is going to sponsor the in-service doctors for the Family Medicine programmes.

Dr. T. Sundararaman, Executive Director, NHSRC spoke on 'How will India benefit from Family Medicine programme'. He argued from the viewpoint of the 'requirement and current functioning of the health service delivery in the country' that the Family Medicine practitioner is essential to address the gap in specialists in the public health system and in rural areas, and would also improve the quality of primary care. Family Medicine practitioners would play a major role in limiting unnecessary referrals and unnecessary conversion of primary care to tertiary care which is the bane of 'profit oriented' and 'supply driven' business models. He was optimistic that Family Medicine practitioner will not only increase access to care, but also help restore ethical foundations of care, and provide care that is more compassionate and holistic.

Dr. Raman Kumar, President, Academy of Family Physicians of India also spoke on the occasion. He highlighted the problems with the current system of carrying out Family Medicine courses and the pursuit of the Family Medicine practitioners in addressing these gaps.

The inaugural session was followed by 3 sessions; National Consultation Family Medicine, International learnings on Family Medicine and a discussion on Indian situation of Family Medicine.

NCFM, 2013

Sh. Prasanth K S, from NHSRC and Convener, National Consultation on Family Medicine (NCFM) 2013, opened up the consultation by introducing the themes of the consultation and also the context in which these themes are discussed. He shared the experience of working with the NRHM supported PGDFM programme and the response received from the states. He also highlighted on the huge specialist shortage at the peripheral level public health institutions, especially in the high focus states and the requirement to augment this in a fast track mode by having a multi-skilled person /team at the secondary care level who will be able to manage between them most of the cases and are also able to do C-sections, blood transfusions, minor surgeries, management of communicable diseases etc. He also shared that currently none of the Family Medicine programmes that run in the country are recognized by the Medical Council of India, leading to lot of ramifications. He also shared that it is important that the team available at the CHC level has nurses also who are trained in Family Medicine.

He then invited the speakers for making presentations as per the themes.

Theme: 1
Skill Requirement of FM Doctor at Secondary Care Level

Dr. Jachin Velavan from CMC Vellore, in her presentation proposed the skills and competencies to be acquired by a family physician to practice at the CHC level. The core competencies would include life saving surgical, obstetric and anaesthetic skills along with management of chronic diseases and women's and child health. She argued that a specialist who is only capable of taking a fraction of the workload at the CHC level is expensive for the health system. If one try to address the huge gap of specialists at the secondary / tertiary care level, it will take long years and even if India achieve this, there will be a lot of 'falls between the cracks', like Dermatology, Psychiatry etc. With the current pace at which specialists are trained, it will take a couple of decades to fill

even the existing vacancies. She also proposed structured MD and diploma family medicine courses to be delivered at the district hospital for training of family medicine physicians. Dr. Velavan also suggested the training of a cadre of family practice nurses to supplement the work of family physicians.

Dr. Sunil Abraham from CMC Vellore, pointed out the deficiencies in a MBBS doctor against the requirements of a Primary care doctor. The multitude of health conditions such as child's health, women's health, adolescent health, NCDs, etc for which the family physician must be trained were elaborated by him and also the need to have multi skilled generalists for providing universal health coverage, quality health care and cost effective care were also stressed upon.

Prof. Bob Mash, from South Africa, elaborated how family medicine principles can be instrumental in achieving universal health coverage. He described effective primary care, family medicine principles and medical generalism as means to achieving universal health coverage. Prof. Mash described the role of the family physician as a care provider at the district hospital level, consultant to the primary health services, capacity builder, supervisor, manager and a community leader. The 'Victoria Falls Declaration on Family Medicine in Africa, 2012' has been made which calls for strategic action to train graduates in family medicine, develop their curriculum and prepare for their continuous professional development. He said such a firm decision will have to be taken by India as well.

Theme: 2
Family Medicine in Post Graduate Curriculum

Prof. Rajendran, LSAS (Life Saving Anaesthesia Skills) trainer from Tamil Nadu in his presentation on 'Anaesthesia curriculum in Family Medicine course' described a plan on how anaesthesia skills (currently delivered through 18 week LSAS programme) will be incorporated into the 3 year family medicine course. The basis for the argument is that the currently run LSAS programme (Life Saving Anaesthesia Skills) equips the MBBS doctor posted in CHCs to

team up with the EmOC trained doctor in providing C-Section services. He argued that the same curriculum can be spread out over the 3 years in the MD (Family Medicine) programme as well. The specifics of the basic sciences training and the advanced theatre skills to be acquired by the family medicine practitioner were elaborated in his presentation. He calls for 4 weeks of training in anaesthesia during each of the 6 semesters and elaborates on postings at the anaesthesia department, call duties and postings at the general surgery, orthopaedics and obstetrics & gynaecology departments as well. He laid emphasis on the continuity of the training programme and pointed out that discontinuity hampers the acquisition of skills.

Prof. C. Ravichandran Paediatrician, Kanyakumari Medical College, Tamil Nadu listed the skills in child health a family medicine resident is expected to acquire. He suggested newborn care, preventive and promotive child health care, nutrition of children, identification and management of acute illnesses in the children including stabilization before referral, follow up of chronically ill children and counseling of the family & community as core competencies to be acquired during the post graduate course.

Prof. Surekha Tayade from MGIMS (Mahatma Gandhi Institute Medical Sciences), Wardha, described the emergency obstetric skills that a family physician must be trained in. A three tiered approach was suggested. The first tier would comprise of ambulatory /basic maternity care, second tier consists of comprehensive maternity care/ vaginal delivery and the third tier contain advanced maternity care/cesarean section. The first, second and third tier competencies would be acquired in 2, 4 and 6 months of training respectively. Prof. Tayade urged that developing these clinical and procedural skills among family physicians would bring about a perceivable change in maternal health over due course of time. Professor also put forward a couple of arguments for and against the inclusion of EmOC skills in the Family Medicine PG curriculum. While Childbirth is core event to formation of family and integral to FM & Continuity of care, ensuring that the various programs provide adequate training volumes to ensure competency is a concern.

Dr. Kirubah David from CMC Vellore, based on background material of the DNB curriculum for FM training, WHO - WONCA document on 'Specialist Family Medicine training in South East Asia in 2003', and South African consensus document on Core Clinical Skills in Family Medicine developed a draft on 'Essential Family Medicine Skills'. Through an online survey sent to interested participants on the listing of 'Essential Family Medicine Skills' presented the findings with responses grading the skills as 'Skills – Essential / Elective / Not needed / Not sure' categories for further review and comments.

Theme : 3
Family Medicine at Undergraduate Curriculum

Dr. Kay Mohanna from Keele University, UK talked about incorporating family medicine as a part of the UG curriculum. The UG curriculum must focus on 5 thematic areas – scientific basis of medicine, information management skills, individual, community and population health, quality and efficiency in health care and ethics, personal and professional development. Twenty percent of the curriculum could consist of general practice and will be distributed throughout the 5 years. Learning will be through Problem-based learning (PBL), case-based learning and case-illustrated learning and student selected components (SSCs) will also be added. Dr. Mohanna puts forth that formative and summative assessment by means of key feature problems and situational judgement tests is essential as part of evaluation.

Prof. Katrina Butterworth from Nick Simons Institute, emphasised the need to include family medicine as part of the UG curriculum. Prof. Butterworth stressed that this is so because it provides all students with generalist physician skills and will also influence more students to take up family medicine as a career choice. The Nepali experience with introduction of GP in a few medical colleges has been explained and also its relevance in the Indian scenario, as majority of the Indian population are rural or the urban poor whose most needs can be catered to by the family physician. It is suggested that the UG family medicine curriculum must be based on needs assessment and good rural physicians who will serve as role models must be roped in to serve as faculty.

Dr. Poonam Varma Shivkumar from MGIMS, Wardha presented how Family Medicine befits the UG curriculum. The current scenario where teaching institutions focus on rare diseases and give importance to specialist services is to be discouraged. A curriculum encompassing all years of medical school involving all departments is to be formulated and it is recommended that the curriculum should be taught by a variety of methods like seminars, case presentations, clinic social case studies, log books and research projects in addition to class room lectures. Assessment is to be both formative and summative and must include written exams, clinical exams and OSCE with weightage if necessary.

Theme : 4
Family Medicine in Nursing

Dr. Loveleen Johri from USAID, talked about the role of Family Medicine in nursing. The concept of Nurse Managed Health Clinics (NMHC) run by advance nurse practitioners was floated. Other staff at the NMHCs can be social workers, public health nurses, and physiotherapists and collaboration with physicians may also be considered. The Arlington model of NMHC was described and its relevance to India has been emphasized. Dr. Johri argued that NMHCs could work as an effective means of providing comprehensive care to the people in areas underserved by physicians in a cost effective manner.

Dr. Manju Chuggani from Hamdard University, gave a presentation on 'Family Medicine in Nursing'. She gave examples from world over to substantiate that the improvements in the key indicators in Maternal and Child health have resulted when they moved from specialist or doctor based care to nurse managed care. She shared that this model is cost effective and efficient as well. For India two options were suggested; one Nurse trained in Family Medicine to team up with the Family Medicine doctor to offer comprehensive set of services. Two; in instances where doctor is not available, the Nurse (FM) will work as 'Nurse practitioner'.

Theme : 5
Governance & Regulatory Issues in Family Medicine

Prof. S Chhabra from MGIMS, brought out the governance and regulatory issues plaguing family medicine. The syllabus for family medicine, certification, recognition, employment opportunities and the accountability of the family physician towards society are still unresolved issues. Dr. S Chhabra shared concerns like 'who will be the trainers?', 'where they will be located?' and whether they would be under a separate department. Dr. S Chhabra also wanted experts to debate on what would be the appropriate name for the program and are we restricting it to 'Medicine' or are we including 'Surgical skills' also. She highlighted the role of MCI and urged that the council decides on the 'recognition' status of Family Medicine (programmes existing and newly proposed) soon.

Dr. Jachin Velavan from CMC Vellore, shared that if Family Medicine programmes are going to be sponsored by government for the 'in-service' doctors, it is imperative that service obligations are part of the contract. The State also needs to define cadre & career pathways for the Family Medicine doctors / nurse. Respective professional organizations should take care of the CME and CPD. Compulsory revalidation must be taken care of by the accrediting authority.

SESSIONS ON INTERNATIONAL EXPERIENCE

Dr. Garth Manning from WONCA (World Organisation of Family Doctors) quoting Baicker & Chandra, Health Aff 2004 and Wennberg et al, Health Aff 2005, described that areas with high use of resources and greater supply of specialists have neither better quality of care NOR better results from care, and that countries have achieved better health outcomes, greater patient satisfaction, lower prescribing and healthier populations through emphasis on primary care systems. He proposed that a family physician must be clinically competent, have expertise in management of common problems, coordinate care and involve in research and continuous professional development and take up the roles of care provider, decision maker, communicator, community leader and manager, in order to deliver appropriate care.

Prof. Bob Mash from South Africa, in his presentation on 'Building consensus on Family Medicine in Africa' puts forth the skills to be acquired during the training period. In African countries, the family physician must handle the patient taking a bio-psycho-social approach in an ethical manner. He must also take a leadership role and facilitate the resources of the community for ensuring health. Training is provided at various levels of CHCs, district hospitals and regional hospitals. They have eligibility criteria to take up the exit exam and both written parts and OSCE must be attempted as part of the exam. A research assignment must also be done to successfully qualify the final exam to become a family physician.

Dr. William Chi Wai Wong, from Hong Kong in his presentation described the role of family physicians in improving the health of the marginalised groups. He argued that inequities in health among the marginalised groups can be addressed by family physicians. He particularly took example of female sex workers who have poor health outcomes and quality of life and adds that how

inequities faced by them is best addressed by family physicians who will be able to facilitate greater participation of the patients in healthcare. The Hong Kong programme is an intensive post-graduation plus residency providing a high range of skills.

Dr. Francisco Campos, former Secretary (Health) from Brazil, shared that Universal Health Care is a Citizenship right in Brazil since it is guaranteed by the Constitution itself. He shared that 100% of population depend on NHS' health promotion and high cost treatments. The 'Family Health Teams' (10 member team comprising of doctor, nurse, dentist and community health agents) within the NHS is playing a key role in delivery of primary care. The system is highly decentralised and managed by municipalities. Under the NHS an open university, (una-sus) is formed which is a collaborative network of educational institutions, a repository for educational resources for health and also provides health worker information system. This is the largest national open access / open educational resources repository in Latin America. He shared that similar models can be adapted in India also. Here the emphasis is not on a post-graduate degree, but continuous skill up-gradation of primary care practitioners.

Prof. David Mant from Oxford University, UK put forth the argument that primary health care is useful to reduce costs, improve health outcomes and to bridge social inequities in health. He identified the problems with primary health care as mainly in the areas of staffing, governance and leadership. He proposed that focusing on staff wellbeing and flexibility in roles could improve staffing, autonomy etc. Rational prescription and maintaining international standards of quality can solve governance issues and improving existent and establishing new training schools with international partnerships will help address leadership issues. He shared a set of suggestions for India;

(a) Focus on high quality clinical staff for primary care

(b) India's strength in information technology could be applied to greatly increase the potential for effective governance of primary care.

(c) The current leaders in hospital medicine and public health in India bear a responsibility to train a cadre of leaders in primary health care.

Towards implementation of the same, the key evidence needed is whether the conditions necessary for the proposed solution to be effective will be met locally or not.

Prof. Clara Gerada of RCGP, UK made observations on the existing state of general practice in the UK. She highlighted the mandatory certification and validation processes that a GP must undergo to prepare for their role adequately. Difficulties of working in a rural area, career progression and a still primitive regulatory framework are issues for which solutions and support were sought.

Dr. Tabinda Ashfaq from Pakistan, explained the entire gamut of family practice training provided at the undergraduate and postgraduate level in Pakistan. The Family Medicine programme in Pakistan started in 1972. The country introduced family medicine in the undergraduate curriculum in 1986 in Aga Khan University. Though the program has strengths of catering to the needs of the community, the challenges of low awareness among the people, absence of adequate training and scarcity of expected jobs are yet to be solved.

Mark Zimmerman from Nick Simon's Institute, drew heavily from the Nepali context of family medicine and found relevance for it in the Indian scenario. The MDGP program in Nepal is a 3 years post-graduation and the training is imparted at the level of the district hospitals where they will serve later. The MDGPs are ensured that they have a good staff support program and are also eligible for scholarships. After the introduction of MDGP programme, there has been considerable increase in the OP, IP, and delivery rates and greatly increased the number of secondary case management of all communicable and non communicable diseases including all basic surgeries. The hospitals also started offering C-section services. Such an incentivised approach may also work in the Indian CHCs where there is a dearth of specialists.

Michael Kidd from Australia, described General Practice Education & Training Ltd, an initiative by the Australian Government to address the workforce shortage of GPs and to deliver postgraduate vocational education and training through a regionalised model. The Australian General Practice Training

program (AGPT) under GPET is a 3 year program on clinical competencies and rural practice with an additional year for FACRRM (Fellowship of Australian college of Rural and Remote Medicine) and FARGP candidates providing advanced specialist skills. The training program is delivered by regional training providers and is therefore, regionally responsive but challenges with vertical integration, capacity, curriculum and workforce distribution still remain.

Dr. Riaz Qureshi from King Saud University, Saudi Arabia, explained about the MRCGP International, South Asia Examination. The programme is conducted putting the South Asian scenario in context. The eligibility for the exam and the component parts of the exam were detailed. The exam consists of written as well as OSCE methods and clearing both of them is necessary. The topics that are covered and additional resources that add value while appearing for the MRCGP International examination were also explained.

Prof. Mala Rao presented the importance of primary health care in India. An example is drawn from the UK-USA experience where UK has achieved reduction of mortality cost effectively whereas USA has achieved the same with least cost effectiveness. The lesser increase in catastrophic health expenditure in AP is partly attributed to the Arogyasri health scheme. She details that what UK and India need to learn from each other is that it is possible to provide holistic, patient focussed care using low technology and by a multidisciplinary team close to the patient and community itself.

Prof. Pratap Narayan Prasad from Nepal described the post graduate training program in Nepal called 'MDGP'. He emphasised that in resource poor countries family medicine experts should learn advance clinical skills to be able to practice independently in community settings. He shared that after three years of training in Nepal the candidates are able to handle all major emergencies, including provision of C-Sections, Spinal Anaesthesia and are helpful in preventing maternal mortality in the country.

SESSIONS ON NATIONAL EXPERIENCE

In the Session on National Experience, the discussions were held by the representatives from Medical Council of India, which is the statutory body providing licence to practice in India; National Board of Examination, which is awarding Diplomate National Board in Family Medicine; Director General of Health Services, which is the technical capacity to Ministry of Health & Family Welfare; Academy of Family Physicians of India, which is an association of Family Medicine practitioners in India; Ministry of Health & Family Welfare, Government of India and academic institutions like CMC Vellore, which is conducting an NRHM supported 2 year Postgraduate Diploma in Family Medicine Programme.

Dr Bipin Batra from NBE, discussed about the DNB Family Medicine program conducted by the National Board of Examination. He shared that there is now more emphasis on training conducted in community settings. He also informed that family medicine is gradually becoming a popular choice of medical graduates recently and all seats of DNB family medicine have been opted during the recent counselling of the NBE.

Dr Raman Kumar from AFPI, shared the present status of medical education system and highlighted the challenges in developing academic family medicine program in the mainstream medical education system. He pointed out that medical education system is largely based in tertiary care medical centres and family physicians as well as primary care doctors are not eligible to become faculty due to regulatory barriers. He argued for academic institutionalization of community health services.

Dr K.M Abdul Hasan, gave a presentation on the activities of the Indian Medical Association College of General Practitioner (IMA CGP) related the family medicine program.

Brig MD Venkatesh discussed about that strict referral system followed in armed forces. Direct referral to specialist doctors in not available routinely in the armed forces medical services. He informed that several hospitals in the armed forces are already affiliated to NBE and are running DNB family medicine training program.

Dr Raman Kataria presented the perspectives of NGO sector and highlighted the challenges in delivering primary health care to the rural population of Chhattisgarh. He briefly discussed the medical conditions commonly encountered in the rural setting and how effectively they are being handled at the peripheral settings by family medicine doctors.

Dr Vinod Shah presented the rationale behind initiation of PGDFM program at CMC Vellore. He argued that training and skill enhancement of general practitioners and medical officers, who form the major part of the public health workforce, can tremendously impact the provision of medical health services through public health systems.

RECOMMENDATIONS

General

(a) The secondary care level institutions will require a muti-skilled doctor / nurse team (Family Medicine doctor and Nurse) having competencies to provide first referral support or secondary care for a wide variety of RCH, communicable and non-communicable diseases. This would include emergency obstetrics and child care, anaesthesia as required at this level, minor surgeries and some life saving ones, trauma care, management of, chronic conditions, communicable diseases etc.

(b) The options agreed upon include i) an MD (Family Medicine & Surgery) for doctors and MSc. Family Medicine (Nursing) / Nurse Practitioner for Nurses ii) diplomas in Family Medicine- under NBE and iii) opportunities for skill up-gradation of primary care providers – both in private and in the public sector.

(c) The training of Family Medicine must be held in community settings with sufficient rural exposure

(d) Faculty training programmes must be instituted to support the Family Medicine courses

(e) States to be allowed tweaking of the course content based on local requirements – there would be a mandatory core- with optional additions that the states could mandate for themselves.

(f) Family Medicine (Nursing) will explore possibilities of a nurse (i) teaming up with Family Medicine doctor at secondary care institutions (ii) perform independent tasks in the absence of a doctor

(g) International training models must be referred to by the Government / MCI / NCI while devising the Family Medicine programmes

(h) All UG programmes must start with rural orientation and primary care models

(i) CME / CNE must be 'built in' to the Family Medicine and surgery programme

(j) Family Medicine programmes must be subjected to periodic review by students / FM graduates / academicians / policy makers

(k) A core group of experts to work on (i) draft PG curriculum (ii) review and build on the NBE approach (iii) review UG curriculum (iv) approaches

usually on e-learning platforms of skill up-gradations with certification of the MBBS doctors seeking additional skills (v) certification & re-certification criteria's for Family Medicine programmes

Central Government

(a) Communication to the States urging them to start Family Medicine programmes for doctors and nurses and strengthen their district hospitals or suitable public hospitals and not-for-profit hospitals to act as centers accredited for family medicine programmes.

(b) Communication to the States urging them to issue G.O on making Family Medicine degree a desirable qualification for posting at secondary care (CHC, FRU, SDH) public health institutions. The rule could read that a family medicine specialist- MD or NBE or other accepted qualification –as notified- could be selected against any vacant post of the five mandatory specialists in every CHC (surgeon, general physician, obstetrician, pediatrician, anesthetist)- and they could be paid on specialist terms.

(c) Financing the e-learning and certification platforms to be developed by states and family medicine associations to offer continuing education programmes for general practitioners in private sector and for primary care doctors in the public sector.

State Government

(a) Issue G.O mandating all Medical College hospitals to have a department of Family Medicine.

(b) Develop guidelines on career progression of Family Medicine professionals.

(c) Issue G.O that all faculties of Family Medicine (including Medical college teachers) will have mandatory working hours at rural centres which are training sites of the FM programmes. Develop faculty development programmes for the same.

(d) Reserving seats for in-service doctors with mandatory service obligations in the Family Medicine programme.

(e) Follow up and implement the central guidelines as stated earlier - with necessary adaptations to suit their situation. For example many states may require family medicine to be equivalent to specialists even in district hospitals, whereas for others the gaps would be only in remote CHCs.

Medical Council of India (MCI)

(a) Formulate guidelines for recognition of Family Medicine programmes (including currently running programmes (e.g. DNB (FM))

(b) Formulate curriculum for MD Family Medicine & Surgery which takes into consideration the needs of the public health care services- especially in rural and under-serviced area- moving the programme away from a de facto bias towards creating internists for corporate emergency care settings.

(c) Develop training site criterions for undertaking Family Medicine programmes (Academic accreditation of community health services)

(d) Incorporate competency based training and evaluation methods (e.g. OSCE etc.)

(e) Develop guidelines on 'who can be a faculty for the Family Medicine programme' and criteria to have points for 'experience of working in rural settings' rather than 'publications' (doctors working in community settings to come under the eligibility criteria)

(f) Relook the undergraduate curriculum for emphasizing contents relating to Family Medicine and Primary care

Nursing Council of India (NCI)

(a) Formulate guidelines for recognition of Family Medicine (Nursing) programmes

(b) Formulate curriculum for Family Medicine (Nursing)

National Board of Examination (NBE)

a. Formulate / Work with the expert groups for curriculum upgradation.

b. Expand the programme without any compromise on quality, by encouraging faculty development and teaching programmes.

University

(a) Process for conduct of MD (Family Medicine & Surgery) and Family Medicine (Nursing) courses

(b) Accredit study centres / colleges / rural hospital settings for conduct of Family Medicine programmes

ANNEXURE 1
AGENDA OF NCFM, 2013

8.00 Onwards Registration &Tea	**DAY 1 SATURDAY** **20th April 2013**	
Plenary Session 0900 – 1000 hrs	**Multipurpose Hall (Hall A)** **Session Chairs: Prof. Vikas Bhatia & Prof. Bob Mash** **0900-0915 hrs :** WONCA Healing the World: Dr. Garth Manning **(CEO WONCA)** **0915-0930 hrs : Family Medicine in South Asia** Dr. Preethi Wijegoonwardene **0930-0950hrs :How to make Family Medicine a preferred career choice for Indian Medical Graduates- Challenges and Solutions -** Dr. Santanu Chattopadhayay **CEO NationWide**	
1000 – 1130 Inauguration	**Chief Guest:** Shri Keshav Desiraju, **Secretary (H&FW) MOHFW Government of India** **Welcome:** Dr. Raman Kumar, President, Academy of Family Physicians of India **Address by Guest of Honour:** Global Challenges to Family Medicine Prof. Michael Kidd **President Elect, WONCA** (World Organization of Family Doctor) **Keynote address:** Family medicine in the context of Universal Health Coverage Prof. Srinath Reddy, **President, PHFI** **Family Medicine: Where we were, where we are!** Dr. Purushotam Lal, Member, Board of Governors, Medical Council of India **How will India benefit from family medicine program?** Dr. T Sundararaman, Executive Director, NHSRC, NRHM, MOHFW & GOI **Address by the Chief Guest**	
1130 – 1230	**Hall A (Multipurpose Hall)** **Concepts and Models** **Session Chairs:** **Dr. Garth Manning &** **Dr. Alwyn Ralphs** 1130 -1150 **Health System in India: Emerging Role of Family Medicine -** Dr. Sunil Abraham 1150-1210 **Role of Family Physicians in improving health for marginalised groups** Prof. William Wong 1210-1230 **Dual Disease Epidemic, Role of GP & Culture –** Prof. Dr. S. Arulrhaj	**Hall B (Conference Hall 1)** **National Consultation** **Expert Group Discussion** (Convened by NHSRC , NRHM, MOHFW, Government of India) **Expert Group Discussion : Skills in FM for CHC level Panel:** Dr. P Padamanaban Dr. Prasanth K S Dr. Jachin Velavan Dr. Raman Kumar Dr. Rajendran Dr. Parthasarathy Dr. Mark Zimmerman

1230 -1330	**Expert Group Discussion** **Family Medicine at Medical Colleges -PG Skills** **Panel:**	
	Dr. Kirubah David Prof. Bob Mash Prof. S Chhabra Prof. Pratap Narayan Prasad	Dr. Ravichandran Dr. Ratnakumar Dr. Rajendran Prof. Vikas Bhatia
1330 -1330	Lunch	
1430-1530	**Session Chairs:** **Dr. Ramnik Parekh &** **Dr. Preethi Wijegoonwardene** **1430-1510** **Strengthening UK-India collaboration for Primary Care. What progress have we achieved?** Prof. David Mant & Prof. Mala Rao **1510-1530** **Practice of Clinical Prevention** Dr. Shamita Misra	**Expert Group Discussion** **Family Medicine at Medical Colleges - UG curriculum & Trainee Assessment** **Panel:** Dr. Jachin Velavan Prof. Katrina Butterworth Prof. Poonam Shivkumar Prof. Pankaja Raghav Prof. Kay Mohanna Dr. Vidya Ramachandran Dr Venkatesan Pandian Dr. Surekha T
1530 -1630	**Session Chairs** **Dr Shamita Misra &** **Dr. Prince Christopher** **1530-1600** **How MDGP Doctors are Transforming Nepal's Remote Hospitals** Nick Simons Institute (Nepal) Dr. Amogh Basnyat, Dr. Mark Zimmerman, and Dr. Phanindra Baral	**Expert Group Discussion** **Expanding scope of FM: Family Medicine in Nursing** **Panel :** Dr. Manju Chuugani Dr. Niti Pall Prof. Alka Ganesh Dr. Lovleen Johri
1630 -1700	Tea Break	
1700 -1800	**Session Chair: Dr. Sunil Abraham &** **Dr. Neeti Rustagi)** **Emerging Models in Family Practice in India (Symposium)** CHC Public Sector - Dr. Piyush Jain, Nationwide - Dr. Santanu Chattopadhyay Pathfinder -Dr. Niti Pall, Ross Clinic (Dr .Devashish Saini) Family Clinic (Dr. Pragnesh M), CMC Vellore (Dr. Venkatesan Pandian)	**Expert Group Discussion:** **Governance & Regulatory issues** **Panel:** Dr. Prasanth KS, Prof. Rita Sood Prof. Michael Kidd Prof. David Mant Dr. Raman Kumar
1930 Onwards	**Banquet**	

0800 Tea	**DAY 2 SUNDAY** **21st April 2013**	
Plenary Session 0900 – 0930	**Multipurpose (Hall A)** **Key Note Address: Generalism in Medical Education Dr. Clare Gerada Chair RCGP UK**	
0930 – 1130	**Hall A (Multipurpose Hall)** International perspectives on Family Medicine **Chair:** Dr. T Sundararaman, ED, NHSRC, MoHFW, GOI	
	0930-0950 **Building consensus on Family Medicine in Africa** Prof. Bob Mash **0950-1010** **Family Medicine as a specialty and as a public health programme - The Brazilian experience.** Dr. Francisco Campos **1010 -1030** **Rural GP training in Nepal** Prof. Pratap Narayan Prasad	**1030-1050** **District Hospitals in Nepal** Dr. Mark Zimmerman **1050-1110** **Family Medicine Training : Perspectives from Australia** Prof. Micheal Kidd **1110-1130** **Birth of Family Medicine in a Nation (USA)** Dr. Jeffery Lemann
1130-1145	Tea Break	
1145-1300	**National perspective and future directions** **Chair:** Shri. Keshav Desiraju, **Secretary (H&FW) MOHFW, Government of India** **National Board of Examination** **DGAFMS:** Ministry of Health and Family Welfare **Nursing Council of India** Academy of Family Physicians of India CMC Vellore	
1300- 1400	Lunch	
1400-1530	**Recommendations of the National Consultation on Family Medicine: Prasanth K S, Convener, National Consultation** **Chair:** Dr. Vishwas Mehta, **JS (HR) with** Dr. Francisco Campos, **Former Secretary (Health), Brazil** **Panel:** Dr. T Sundararaman, Dr. Ratnakumar, Dr. Rajendran, Dr. Raman Kumar, Dr. Jachin V, Dr. Manju Chuugani, Dr. S Chhabra	
1530-1630	**How Family Medicine can widen the scope of helping patients globally - sharing MSF experience by an Indian MD -** Rimmi Manners and Farhat Mantoo	**Round Table Discussion: Education and training for family medicine in India** **Conveners:** Dr Kay Mohanna Dr. Adrija Rahman Dr. Alwyn Ralphs Dr Niti Pall
1630	Valedictory	

ANNEXURE 2
LIST OF PARTICIPANTS

S. No.	Name	Organization
1	K S Prasanth, Convener, NCFM	NHSRC, NRHM, MOHFW, GOI
2	Raman Kumar, Chairperson, FMPC	Academy of Family Physicians of India
3	Vandana Agarwal, Co-chair, FMPC	Academy of Family Physicians of India
4	Alwyn Ralphs	WONCA
5	Bob Mash	Stellenbosch University, South Africa
6	Basharat Ali	South Asian Primary Care Research Net Work, Pakistan
7	Clare Gareda	Royal College of General Practitioners, UK
8	David Mant	Emeritus Professor of General Practice University of Oxford
9	Francisco Edurado De Campos	Federal University of Minas Gerais, Brazil
10	Garth Manning	WONCA
11	Jeffery Lemann	University of IL College of Medicine, USA
12	Janaka Ramanayake	University of Kelaniya, Sri Lanka
13	Katrina Butterworth	Patan Academy of Health Sciences (PAHS), Nepal
14	Patan Academy of Health Sciences (PAHS), Nepal	Keele University, UK
15	Kay Mohanna	Keele University, UK
16	Kanu Bala	Academy of Family Physicians, Bangladesh
17	Mark Zimmerman	Nick Simon's Institute
18	Michael Kidd	Flinders University, Adelaide
19	Pratap Narayan Prasad	Tribhuwan University Teaching Hospital, Kathmandu, Nepal
20	Preethi Wijegoonwardene	WONCA (South Asia), Sri Lanka
21	Riaz Querashi	King Saud University, Riyadh
22	Sajida Naseem	Shifa College of Medicine, Pakistan
23	Waris Kidwai	Aga Khan University, Pakistan
24	William Wong	The University of Hong Kong, China
25	Bipin Batra	National Board of Examination, New Delhi
26	Purushotam Lal	Medical Council of India
27	Surekha Sama	Nursing Council of India
28	Pradeep Saxena	CBHI. New Delhi

S. No.	Name	Organization
29	T Sundararaman	NHSRC, New Delhi
30	K Srinath Reddy	PHFI, New Delhi
31	A C Baishya	NERRC, Guwahati
32	P Padmanaban	NHSRC, New Delhi
33	J N Srivastava	NHSRC, New Delhi
34	Rajesh Narwal	NHSRC, New Delhi
35	Alia Kauser	NHSRC, New Delhi
36	A K Singh	NHSRC, New Delhi
37	Amit Mishra	NHSRC, New Delhi
38	Rita Sood	AIIMS, New Delhi
39	Puneet Misra	AIIMS, New Delhi
40	Sonu H Subba	AIIMS, New Delhi
41	Vikas Bhatia	AIIMS, Bhubaneshwar
42	Sonu Subba	AIIMS, Bhubaneshwar
43	Pankaj Bharadwaj	AIIMS, Jodhpur
44	Pankaj Raghav	AIIMS, Jodhpur
45	Neeti Rastogi	AIIMS, Jodhpur
46	Vidya Ramachandran	ICMR, Chennai
47	Atul Kotwal	Armed Forces Medical Services (Medical Research), New Delhi
48	Vinod Shah	CMC Vellore
49	Alka Ganesh	CMC Vellore
50	Jachin Velavan	CMC Vellore
51	Kiruba David	CMC Vellore
52	Venkatesh Pandian	CMC, Vellore
53	Sunil Abraham	CMC, Vellore
54	S Chhabra	MGIMS, Wardha
55	Poonam Shivkumar	MGIMS, Wardha
56	Surekha Tayade	MGIMS, Wardha
57	Mala Rao	University of East London, UK
58	Arulraj	Indian Medical Association
59	Ratnakumar	Madras Medical College, Tamil Nadu
60	Rajendran	Madras Medical College, Tamil Nadu
61	Ravichandran	KMC, Tamil Nadu
62	Ramnik Parekh	FFPAI (Federation of Family Physicians Associations of India)
63	Rimmi Manners	MSF
64	Farhat Mantoo	MSF
65	Billy Stewart	DFID

S. No.	Name	Organization
66	Ruhi Saith	Oxford Policy Management, New Delhi
67	Niti Pall	Pathfinder Healthcare Developments, UK
68	Lovleen Johri	American Embassy
69	Manju Chhugani	Jamia Hamdard
70	T P Jayanti	Kilpauk Medical College, Tamil Nadu
71	R Arunmozhi	Madras Medical College, Tamil Nadu
72	Sunanda Gupta	WHO (Retd.)
73	Vasumathi Sriganesh	Quality Medical Knowledge Foundation
74	Santanu Chatopadhyay	Nationwide Primary Healthcare Services
75	Subrahmanyam Karuturi	Doctors Hangout
76	Biplab Jamatia	School of Health Sciences, IGNOU
77	Rajnesh Pandey	Bilaspur
78	Anand Ratan	Fortis Hospital
79	Vijilasac David	PJCH, Jharkhand
80	Budh Ram Ratre	Chattisgarh
81	Deepak Dahia	Ross Clinics
82	Kamal Kumar Soni	Bilaspur
83	Rinku Ghosh	MFD Pvt Ltd
84	Nandini Vallath	Bangalore
85	Sameer T	NSI
86	Arvind Shah	NSI
87	Susan Clarke	Satibari Christian Hospital, Guwahati
88	Jai Vir Singh	K G Medical University Lucknow
89	Utpala K	Gujarat
90	Pambhai	Rajendra Nagar
91	US Maxotrice	Raipur
92	Rajnish Pandey	Apollo Hospitals
93	Nandini Vallath	Bangalore
94	Deepak Ganapathy	Chennai
95	Pramod Ranjan Roy	Military Hospital, Assam
96	Mohan Kubendra	New Delhi
97	R K Gupta	New Delhi

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