PERSPECTIVE

A Commentary on Perceived Need from Indian Perspective

Ankur Joshi[1], Saket Kale[2], Sameer Phadnis[3]

[1]All India Institute of Medical Sciences, Rishikesh, Uttarakhand; [2]Assistant Professor, Department of Community Medicine, RD Gardi Medical College, Ujjain, Madhya Pradesh; [3]Associate Professor, Department of Public Health, Manipal University, India

Abstract	Introduction	Methodology	Results	Conclusion	References	Citation	Tables / Figures

Corresponding Author

Address for Correspondence: Ankur Joshi, All India Institute of Medical Sciences, Rishikesh, Uttarakhand;
E Mail ID: drankurjoshi7@gmail.com

Citation

Joshi A, Kale S, Phadnis S. A Commentary on Perceived Need from Indian Perspective. Indian J Comm Health. 2016; 28, 3: 309-313.

Source of Funding: Nil **Conflict of Interest:** None declared

Article Cycle

Received: 29/08/2016; **Revision:** 01/09/2016; **Accepted:** 22/09/2016; **Published:** 30/09/2016

This work is licensed under a Creative Commons Attribution 4.0 International License.

Abstract

The current Indian health –care scenario is overwhelmed not only with burden of diseases but also with quality of care and expenditures. The structure of this paper is interwoven around a storyline about a patient and narrations of the active actors involved in the journey of illness including patient himself. The narrations are followed by a commentary as an attempt to decipher the deeper meaning of narration from the population perspectives. The essential aim of this exercise is to establish the necessity of generalist care from a qualitative view-point in Indian context.

Keywords

Care continuum; Primary Health Care; Family Medicine; Point of Care

Introduction

A police-man who was posted in a small town, in a mysterious (to him) manner developed some shakes and jerks while he was enjoying his little sleep after long duty-hours. The puzzled man contacted with a nearby doctor, who habitually and in automation referred him to a neurologist of nearby city without much interposition. The very next day, he met with the neurologist, told him that he had same jerks before as well, after some investigations which were alien to him, he was diagnosed to have General tonic clonic seizures (GTCS). He was told that he had 'Mirgi' so he has to take medicine for long. This anxious and petrified fellow returned to his native town and tried to understand his disease from the same local doctor whom he met initially. Parenthetically this doctor was a fresh graduate and was serving in rural area in lieu with service –bond. He had a set purpose to crack Pre-PG examination and to get entered into Medicine-his dream branch. At that time his focus was to remember the mystic mechanism of p-53 gene. How the Epilepsy and this patient could fit into his structure? Anyway he told the patient that this was the disease of the brain and the medicine was very essential. Patient with this inconsistent information started taking Valproic Acid, single dose in a day. After two weeks, he felt the same jerking episode. On contacting with the PG aspirant doctor, he was advised to visit the same neurologist. One new drug along with increased dose of the first one was the solution offered by neurologist. After this episode he started to have presence of continuous pain and discomfort in his right arm and shoulder which was causing trouble in his routine activity. Therefore, he tried to discuss this issue with one more local doctor who was a postgraduate in medicine, suggested some pain killers for few days. He did not get much relief out of it; subsequently he was referred to an

Orthopedician, as the local doctor recommended of this pain as having a bone connection which is not his expertise (?)….. For the record of avid readers, he was diagnosed with Muscular strain (probable overstretched during seizure episode). Nonetheless he religiously followed all the instructions about the anti-epileptic medicine. After 3-4 months of initial episodes he started developing some strange dislikes for food. He wanted to puke many a times but oddly he was not able to relieve himself freely. One fine sunny day his wife noticed that his eyes were also turning yellow. This phenomenon was known to him as 'Peelia' as already one of his relative had the same yellow eyes once. He rushed directly to neurologist this time without approaching to local doctors as through the previous experiences he knew that anyhow they would refer him to city's 'bade' doctor sahib. Yet the weird and wonderful part was yet to be revealed. This time the neurologist told him that he was referring him to a gastroenetologist as the drugs he was taking might have caused the trouble.

At a first glance this scenario may look little dramatic and full of prejudiced to interested readers yet as Mark Twain said- "There was never yet an uninteresting life. Inside of the dullest exterior there is a drama, a comedy and a tragedy", this set-up can be considered as the factual-fiction or a dramatic-reality.(1)

An illness thoughtfully can be considered as deviation from being perfect in every dimension. As perfection is an optimistic illusion in real word as the element of illness is omnipresent. The fact which makes the issue even more convoluted is that neither illness is a binary phenomenon nor the factors influencing the extent of illness interact in linear fashion. Hence a component of confusion and fuzziness always prevails between what is healthy and what is not. This non-conformist stance is the primitive 'big-bang' point from where all the arguable issues emerge and from where a patient commences his illness journey. The trajectory of this journey is unique for every patient being affected by several effect modifiers related with socio-culturalism, market forces and degree of informational fulfilment. (2, 3)

As there is ambiguity and indecisiveness prevails in the beginning and thereafter, a question seems pertinent at this juncture- whether a fellow traveler (in the form of a health care provider) may help to minimize this uncertainty? If the answer of the question is affirmative, then what should be his characteristic trait? Probably he should be competent enough to satisfy the informational requirement of patient and to optimize the illness journey of patient. He should own a brain with intellect, a heart with feelings and the actions directed to the whole-person and not merely to his physical ailment. This is the point where a generalist approach comes into picture. A generalist approach operationally may be visualized as an offering of the individualized care rendering with an aim to tailor the need of a person irrespective of the underlying disease embedded in his socio-environmental milieu. (4, 5)

The approaches and perceived hurdles to adapt this approach may be further elaborated by self-narrations of the stakeholders in the above scenario.

Epilepsy patient—I don't know even now from what I am suffering from exactly. Doctor tells it is 'Mirgi.' But how could I have got this and more importantly how can I get rid of it? I tried to ask the doctors but some of them are dispatching me to 'bade doctor sahib' as if I am a letter, while I feel terrified and speechless in front of bade doctor sahib. Although he told me I have Mirgi and gave me some medicines to take and yes, he also gave me a pamphlet about Mirgi which says I need to take full sleep and keep myself away from any anxiety and strain. You know, strain and pressure is the part of duty if you are in Police in this country. My duty hours are also very long and irregular as they depend on the requirement of administration. I don't know for how long I need to take these medicines to dispose of this disease? My neighbor told me to take a 'Kadha' for my disease ….should I take it? I am not sure. I have seen some people who were sniffed shoes when they had an attack. will this also happen to me? This must be very disgraceful. Who will answer to my concerns? Now they tell me I have 'peelia' because of medicines. If this is the case then without medicine what will happen to me? I am confused and restless someone please help me!

A book of Clinical Epidemiology very well endorses the importance of shared decision making by labelling both doctor and patient as 'expert'.6 Each patient is an expert in terms of 'expected outcome from medical care' (theoretical framework) rooted in his experiences. While a doctor is expert in terms of 'design the way to achieve the expected outcome'(operational framework) Hence it is

essentially the 'dialogue' between a treating physician and a patient in context with 'felt-need' which makes this collaboration meaningful for achieving some common agenda.(7) The current health system epitomizes (and market-forces endorse) the specialist driven top-down pharmaceutical care in which there seems to be a little space for information flow. The underlying reasons may be thought in terms of excessive convergence of health care, changing social context in post-liberalization era, economical and geographical uneven distribution of resources and prevailing consumerism. However, let's not reach to conclusion so early let's see what the neurologist says-

The neurologist: Hello! I am dealing with the brains of people but my own brain sometimes gets exhausted in this process. My OPD is overloaded with patients. Patients want to bet on the best available option in the city. Sometime I wonder how they decide 'the best', is it by virtue of my title or my earned credentials? Anyway, I feel sometimes I am not able to spend sufficient time for every patient. If I spend much time with a patient, the others who are standing in the queue will suffer. Few days back, a policeman came to me. I wanted to understand his triggering dynamics for his Epilepsy and to guide him further but OPD load was overwhelming as usual so I had to rely only on pharmaceutical management. Would it be good if some doctor at his place could take care of his disease and my involvement would had been for resolving of critical complicated issues? The overall improvement in the economic status, in post-economic liberalization era and escalation of awareness (synchronized with information technology tools development revolution) has granted an opportunity to search for a seeming paramount health –care. This phenomenon may be seen in the light of 'consumerism' in which varieties of products are available for consumers to choose according to their purchasing capacity. Market forces have also promoted this counterfeit model for health care in which a provider is being judged by virtue of his gradation only. These whole sequences of events have resulted into the pseudo- confederacy in which an ill person is tempted to avail the 'premier' services regardless of the factual necessity for the same. Moreover, this has promoted out of pocket expenditure and disproportionate burden on health care. With the consumerism, a physician and a patient both are no longer motivated by compassion and benevolence rather they perceive one-another as customer and supplier. At this instant, it may also be emphasized that this search for premier care has actually accelerated the process of 'purchasing-paradox' in which still under-privileged sections are not able to avail even the quality basic health services as they are not the 'targeted consumers' for health industry. Moreover, till date as there is no define model of 'step-up' health care delivery in the country so there is no structured defined screening, triage and interventions systems are in place at various strata of health care. (8, 9, 10)

PG aspirant: I am not sure from where I should begin. Probably this confusion and agnosticism goes back to my first year in medical school. Our teachers were all alike; they spoke to us in some substantially academic language during lectures which was beyond uppermost threshold to understand by most of us. Sometimes, I tried to focus but it was like as if information was flowing all around but I was not able to take a dip and feel damp in enjoyment. Anyhow thanks to the list of important questions, I completed my initial year. At some point of time during my graduation, I began to realize or it was realized to me that without getting into PG, there was no future ….the entire environment was obsessed with PG entrance preparation. Now I realize that this 'future' business is actually related with earning more money and getting worldly recognition. I don't feel bad about it, this is reality of time. Anyway I took admission in a coaching class during the weekends. They started teaching us important sections (again important is it the key word in current medical education?) of every subject. I was preparing for a step-up while I was not sure about the texture of the step on which I was standing. The lectures were the same I was not able to understand why it was a requirement to remember definition of health and family planning in PSM or why to remember the steps of Extracapsular Cataract Extraction procedure (while I was not allowed to be the part of it). The lectures were bombarding the information on molecular mechanism of p-53 gene and I was not able to clarify about the result of the Liver Function Test to my relatives (they considered me as 'doctor' since my first-year. The whole environment could be defined as 'dissociative' and 'repulsive'. Pre-PG was a distant lighthouse for all of us. Internship was the peek time for PG preparation. Unfortunately, I could not get into it and I had to join rural service in order to sustain after all I am 27 now. Some days back a

policeman came to me. Probably it was a case of Epilepsy. I wish I could help him. But I have never seen such patients during my graduation. I have some bookish knowledge about the patho-physiology and Pharmaceutical management that I conveyed him. I know he is not satisfied with me but either his expectation is more or I am an under-performer I don't know. Probably after completion of my post-graduate degree I will be able to take care of such person.

When a doctor encounters a patient he simply observes and tries to look some known pattern to him in the patient and then he applies them to a broader diagnostic frame. Accordingly, a medical student has to perceive some immediate learning stimulus and applied aspects from whatever he is being delivered for endurance. (11) The largest context in medical education derives from the application of gained information for the beneficence of an individual patient or apparently healthy population. (12) Current curricular structure although offers a pile of information in formative years yet fails to reveal its applied aspect. Moreover, unfortunately this curriculum is unable to separate a useful content from redundant and time-honoured contents. Moreover this curricular structure discourages critical thinking (may be defined from a student's perspective as the ability to extract information, sense making from the information and to find out the scope for that application and then apply it). In order to think critically one needs an individual space and multi-dimensional stimulus for thinking, which is a characteristic of a generalist physician who encounter with variety of patients both in terms of ailments and individualism. (13)

Three inferences can be drawn from this discourse. When we take all these arguments in cohesion, a curriculum (customize to the undergraduate student) which is primarily rooted on the principle of primary health care, derives its direct learning context from patients suffering from frequently prevailing diseases or from the 'perceive health need' of society and that can be operationalized through an individual centric approach seems apt for our country. (14) Simultaneously it is a well-known saying among educationalists-assessment drives learning. (15) May we take liberty to add few words and reframe it as- 'set purpose with assessment in position drives the learning'. Purpose which is emerging here from the Indian medical education perspective is in alignment with generalist approach.

Conclusion

The theme which emerges from all the narrations is of uncertainty and disappointment in all the actors. All of them are trying to adapt but the process of adaptation is actually creating more problems in terms of break in information, trust and service – delivery. As a larger system is constituted by interconnected sub-systems, this speciality driven care is not only influencing the patient care in a negative aspect but also catalysing the separation of medical education from generalist primary care. Authors are willing to share some possible solution for this discontentment and mal-adaptation- first, generalist care should be visualized as a 'conversion point' of the patient care rather than first platform of the patients' illness journey, which he has to leave one day without even knowing the reason, in search of another station never to return again. This conversion point of the care stress the essentiality of patient centred rather than 'organ system' or 'nature of complaint' centred approach of the health care delivery. Secondly, it is required that medical education system must ensure linkages through all sub-speciality and super speciality with generalist care without prejudices of encouraging consumerism on part of the health care givers. Lastly, there is a need to establish bidirectional channels between general and speciality care for keeping the patient into the continuum of care rather offering them 'better' commodity which can be bought by more affluent only creating the perceived purchase paradox.

Authors Contribution

All the authors had made substantial contributions to conception, design, data collection, analysis and interpretation of data; drafting the article, revising it critically for important intellectual content; and final approval of the version to be published.

References

1. Schmidt B. Directory of Mark Twain's maxims, quotations, and various opinions [Internet].www.twainquotes.com; 1997[cited 2016 Jan 4]. Available At: http://www.twainquotes.com/Life.html
2. Enthoven AC. Market Forces And Efficient Health Care Systems. Health Affairs , 23, no.2 (2004):25-27. doi: 10.1377/hlthaff.23.2.25
3. Jutel A. Medically unexplained symptoms and the disease label. Social Theory & Health (2010) 8, 229–245. doi:10.1057/sth.2009.21
4. Stange KC. The Problem of Fragmentation and the Need for Integrative Solutions. Ann Fam Med 2009;7:100-103. DOI: 10.1370/afm.

5. Stange KC. The Generalist Approach. Ann Fam Med 2009;7:198-203. DOI: 10.1370/afm.1003.
6. Fletcher RH, Fletcher SW. Clinical Epidemiology: The Essentials.4th ed. Philadelphia: Lippincott Williams & Wilkins; 2005.
7. Elwyn et al.: A Model for Shared Decision Making.J Gen Intern Med 27(10):1361–7. DOI: 10.1007/s11606-012-2077-6
8. Chatterjee C, Srinivasan V. Ethical issues in health care sector in India. IIMB Management Review. 2013 March 25(1):49–62.
9. James C. Robinson. Managed Consumerism In Health Care.Health Affairs, 24, no.6 (2005):1478-1489. doi: 10.1377/hlthaff.24.6.1478
10. DiMatteo MR. The role of the physician in the emerging health care environment. West J Med 1998; 168:328-333.
11. Fitzpatrick M. The Tyranny of Health: Doctors and the Regulation of Lifestyle.Routledge, Taylor and Francis Group; 2001.
12. Park K. Park textbook of Preventive and Social Medicine 22nd ed. Jabalpur: Bhanot; 2014.
13. Aggarwal S, Sharma V. The problems of medical education in a developing economy: The case of India. Ann Trop Med Public Health 2012;5:627-9.
14. Wormald BW, Schoeman S, Somasunderam A, Penn M. Assessment drives learning: an unavoidable truth? Anat Sci Educ. 2009 Oct;2(5):199-204. doi: 10.1002/ase.102. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19743508.
15. World Health Organization.The World Health Report 2008: primary Health Care-Now More Than Ever [Internet]. World Health Organization; 2008; Available at:- http://www.who.int/whr/2008/en/ (ascessed on 4 Jan 2016)

Figures

FIGURE 1