Changing trends in general practice in Mumbai – a few stray thoughts

Arvind Pednekar

Hippocrates, had he been living now – in India, in Mumbai — would have been too confused to write his famous oath. Perhaps, he would prefer to have nothing to do with it.

In the early 1950s and '60s, Mumbaikars, irrespective of their class, had their own family doctor as an essential part of their family. Nobody then, unlike today, had his or her own paediatrician, physician, gynaecologist or surgeon. The Family Doctor (FDr) or General Practitioner (GP) served families medically and socially. Patients, too, had explicit faith in the FDr. This reciprocal relationship produced the best in the FDr and the patients.

Since the 1970s onwards, with rapid industrialisation, patients became financially affluent. For many patients, employers offered medical perks along with other perks. Such facilities had an abusive effect on the family doctor-patient relationship. The FDr was easily by-passed and the help of other specialists was sought. And these other specialists conveniently did not bother to involve the FDr. The need for the FDr came into the picture only after the retirement of the patient when medical perks disappeared. This scenario changed for the worse by the 1980s when general practice started getting eroded by other specialities. Facilities to patients, which were conventionally given by the FDr or GP, were given by these specialists. Paediatricians were the leaders by snatching the immunisation programme from the FDr. Ante-natal and post-natal care started to be given by obstetricians and gynaecologists. Nowadays even non-medical personnel like beauticians and dieticians have been guiding patients.

All this made it difficult for GPs to survive. The famous scientist Abdul Kalam recently stated that to reach heights self-respect, self-assessment and self-value has to be at their heights. Our senior GPs perhaps never did any of these, and younger GPs, out of fear of competition with seniors, never dared to change, resulting in doctors finding other sources of income, medical, non-medical and even unethical. A big hue and cry was made by the media regarding this last way of income. It is not to justify this in any way, but one must not forget that the GP is part and parcel of society. He has to flow with society's rules and methods. Our country's existing culture being corruption, a GP falling prey to such temptations is not a surprise. Since the medical profession is considered to be noble, this becomes unacceptable and thus an issue for discussion

However, one must admit that in the past 20-25 years, a small percentage of GPs have shown a consistent interest in updating themselves. These few GPs have intentionally distanced themselves from the conventional practice of their seniors. It is observed that most senior doctors have never updated themselves in medical knowledge, and not even in their clinics where they spend most of the day. Buying medical books by a GP was never heard of in the past. Medical book depots will vouch for this. As against this, the above-mentioned small percentage of GPs are regularly exposed to books, journals, seminars and CMEs. The GPA of Greater Mumbai should singularly deserve the credit for infusing awareness in its members for such updating. The IMA and its branches in Mumbai have taken a cue from the GPA and have started offering various such programmes. Due to all this, the GPs of today are definitely well oriented with modern technology.

Despite this, the liaison between GP and patient seems to be getting commercialised. Financial affluence, as said earlier, tends to get patients into doctor shopping. Add to this patients' exposure to media advice offered by specialists and quacks. This media facility provides an excellent opportunity to market the specialist, the benefit to the patient being disputable. Thus specialists create their own way of marketing. Hippocrates, had he been witnessing this, would be turning upside down in his grave.

Awareness of one's own health is seen to be gravely lacking amongst patients in spite of efforts by GP's. Not having a family doctor who has the full medical and social history of the entire family creates a great hollow when a crisis occurs. Eventually, along with patients, the whole family suffers. In such times, having a family doctor and not a specialist is definitely advantageous. Luckily, in Mumbai there still exist a few family doctors and a few family patients. Among them they share most cordial, dependable and also a professional relationship.

The relation between a GP and other specialists has changed dramatically over the years. Typical, the Mumbai scenario of GP- Specialist relations is like this:

The young specialist will make all efforts to remember birthdays, wedding anniversaries and even the colours liked by a GP who refer him the cases. His rapport with the GP will be excellent all the time even if it is not desired. A few years later, on establishing himself, all this recedes (barring those few GPs who keep on referring). A decade later it comes to "Hi, Long time no see." The GP has thus become a stepping-stone.

The GP too exploits the situation, willingly or unwillingly. He gets easily carried away and later gets used to 'receipts'. Eventually, to keep it up he creates references. Who started the ball and who is tossing it is a million-dollar question. However, no efforts on either side are seen to stop this "you scratch my back, I scratch yours" attitude. In the modern days of management this self-marketing and self-promoting is conveniently accepted by both.

To quote a different scene, I had the privilege of a superb intellectual and professional liaison with a senior-most specialist; incidentally he was my teacher too. On a

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domiciliary visit when this specialist was called, after examining the patient he would ask me to offer my opinion freely about the diagnosis and management, and invariably correct me very politely, never in the presence of the patient and relatives.

Such was the rapport between GP and specialist. Now in contrast, on my referring a case to a specialist with a covering note asking for feedback, the specialist will ask the patient to inform me to telephone him. Hospitalised patients get easily tossed form one specialist to another without the GP being informed. The attitude of such specialists is: "What's the need to inform?" Sadly it is only when a doctor himself or his relatives go through such a terrible plight, causing financial drain, that they realise the need for a family doctor. I had, and still have, such senior non-practicing doctors and their relatives as my family patients, some of them are even my teachers. Indeed, it is a pleasure and honour to be a family doctor to a doctor.

The GP-hospital relationship is non-existent in Mumbai. Hospitals, as a rule, do not believe in the GP- FDr concept, except for inviting them as an audience for self-marketing occasions. Not a single hospital in Mumbai has a small line on its case paper for the FDr's name. To gather information about his patients in a hospital, the GP has to go through most unpleasant hassles, right from the doorstep to the treating doctor. The GPA, Greater Mumbai, sorted out this problem a few years back with positive reassurances from hospitals. But this has remained on papers only. A facility for admitting patients under the care of GPs is still unheard of

Hopefully in the future, somewhere in this country there will be a hospital exclusively owned and managed by a GP and an FDr, and only when required would other specialities be called as visiting faculty. It is a dream, though.

We, the present GPs, must realise that we are equally good in our own speciality as compared to any other speciality. And for this, we must basically realise that general practice is a speciality which is not easy to practice. It is not included in medical teaching at the undergraduate level. It requires extraordinary skill to be available quickly, to take decisions quickly and to have sufficient knowledge of all the specialities. All this is self taught, self-developed. These qualities are not required by other specialities. But one wonders, if this is so, why are our fees not on par with other specialities? This could be attributed to the inferiority complex of our seniors resulting in lower fees and lower respect in the eye of patients.

The time has come for all GPs to revolutionise their thinking and method of practice. The modernisation of clinics, and updating knowledge, have to be on the cards. Only then will general practice be placed on a high pedestal in society, which it rightly deserves.

Hippocrates perhaps then will write a better and practical oath for the medical profession of today.

A researcher's view of general practice

I had planned a study to assess GPs' knowledge of diabetes using a quantitative questionnaire based on semi-structured interviews. To pilot my questionnaire I went into a densely populated area of north Delhi.

I stepped into a private GP's clinic, introduced myself, and explained the purpose of my visit. This clinic was small. It had a desk, an old cabinet, a partition behind which the GP examined the patients, a washbasin, and some chairs and benches for patients to sit on. The paint was peeling off the walls. It was the peak of summer with temperatures reaching 44°C, but the fans were not working because of power cuts. There were no patients. The doctor met my pre-prepared questions with disinterest. "What is the point of asking me all these questions? I don't see such patients. Patients never come back to me for follow up," she said.

A patient came to the gate and asked, "How much do you charge?" The doctor said, "Thirty rupees". The patient said in astonishment, "What, 30!" The doctor calmly nodded yes. The patient then inquired, "Medicines?" The doctor said, "You will have to buy them." The patient was further aghast and exclaimed, "What! The other doctors include medicines in that much money." The patient turned and left.

The doctor explained that this was a daily feature. She had qualified at a reputed medical college in Delhi but her 10 years in private practice had left her completely disenchanted. "Non-qualified doctors have ruined the medical practice. They are the ones who get all the patients, not us," she said. Across the road from her a quack, practising as a doctor, was seeing more than 60 patients a day. ...

Soon thereafter, an obese lady in her mid-forties walked in. The doctor examined her and wrote a prescription. The patient left after paying. The doctor said, "She has a urinary tract infection, but I cannot ask for a blood glucose. I can ask only for a urine glucose, as these patients feel that the problem is in the urine. If I insist on a blood glucose she would simply consult another doctor."

The look in the doctor's eyes showed her sense of frustration. The patients' perceived needs, idiosyncrasies, and financial limitations governed her practice. ...

Talking about microalbuminuria, glycosylated haemoglobin and lipids seemed far fetched when getting simple tests was so difficult. It dawned on me that my carefully planned questions about these things seemed almost irrelevant to the GP's clinical practice. Many factors, other than knowledge, determine how doctors practise.

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