FROM THE FOURTH GENEVA CONFERENCE ON PERSON CENTERED MEDICINE: EDUCATION IN PERSON-CENTERED MEDICINE: BRIEF COMMUNICATION

Education in person-centered medicine: Indian perspectives

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Introduction

The origin of person-centered medicine can be traced back to ancient civilizations and traditions, both Eastern (such as Chinese and Ayurvedic) and Western (particularly Greek), which tended to conceptualise health broadly and holistically [1]. The ancient Indian system of medicine, Ayurveda, paid much importance to the person, his family and his circumstances. In education, the Guru - Chela (Teacher - Disciple) relationship was the cornerstone of clinical teaching. Here, the student or the disciple lived with the Guru (the master or teacher) and learned the art of healing by watching, emulating and learning from him being considered, during this time, almost as a member of the Guru's family. The Guru was held in great respect or awe. Ayurveda considered medicine as a great vocation. In fact, to become a physician was considered a gift of God. The physician rendered his services as his responsibility to the people around him. Often, it was without consideration of a fee. Whatever was given as a token of gratitude by the patient or his family was accepted. For this reason, the poor and the under-privileged needed no hesitation in approaching the physician, as no demand for a fee or any form of remuneration would be made.

Modern India

The scenario in modern India has now changed considerably. Modern medicine came to India with the colonization of the country by the British. With little support from the ruling class, Ayurveda lost its patronage and pre-eminence. Modern medicine, with its advanced technology and knowledge, gradually gained more and more acceptance in India. Ayurveda, which could not produce the dramatic effects and cures of modern medicine, declined and, with it, its rich traditions, a major one of which was person-centeredness.

India is now considered as one of the biggest emerging economies of the world. Modern medicine, with its sophisticated technology and ongoing advancements, is looked upon as the 'cure for all ailments.' Unfortunately, with the wave of liberalization and globalization sweeping India, medicine in India, too, has dramatically changed. Medicine is still considered as the noblest profession but is also the costliest, the longest and the most sought after education. During the last two decades, the private sector has become a major provider of medical education. Since there is a lack of government funding and support for private medical colleges, medical education has become very expensive, making it unaffordable for the common man. There has also been an escalation in treatment costs. Many of the best medical institutions and medical colleges in India are now privately owned and administered. While they are contributing immensely to the health of the people as well as in furthering medical education, their high costs have been a matter of serious concern. India has one of the largest sized rich middle class in the world. For them, the high costs of medical education or medical treatment may not be a big concern, but these costs certainly affect the economically weaker sections of Indian Society.

Medicine in India, as in the most advanced countries of the world, is more and more seen as an industry, rather than as a charitable activity. The business of industry is to make profits. When medicine is driven by the profit motive, person-centered medicine becomes the first casualty. There is concern that person-centered medicine may disappear in India very soon, unless concerted action is taken by medical teachers and other medical professionals to arrest this trend. In India, visibility and

attention are given mostly to the super - specialities and highly specialized physicians which vie with each other for newspaper headlines although they form only a minor tertiary segment of medical services in India. They work on the principle of industry profits and this is not the obvious way to encourage the practice of person-centered medicine. The truth is, the narrow apex of tertiary medicine makes no difference to important parameters such as (i) whether every pregnant woman in India will deliver safely; (ii) whether every child will grow to become a healthy adult or (iii) for how long the adult will live without morbidity. The most pressing need is to produce multi-competent physicians who are within easy reach of one's home, whose practice is affordable and who are able to resolve most common medical problems. Thus, what is more relevant and important for India is Family Medicine and the availability of General Practitioners. To them, the concept of person-centered medicine is useful and helpful. But, unfortunately, in India, person-centered care, family medicine and psychiatry are not getting the attention that is necessary.

The doctor to population ratio in India (1:2,083) is too low compared to many developed countries such as the US (1: 362), Russia (1: 236), Cuba (1:169) and elsewhere [2]. For the same reason, the Planning Commission of India [3] aimed at a doctor to patient ratio of 1:1,000. Currently the total number of doctors available in India is 680,000. In order to achieve the ratio proposed by the planning commission, another 600,000 doctors are required for India.

The chance of an Indian becoming a doctor is 1:1000. The availability and dependability of this one person has the potential to make a life and death difference for the other 999. The total number of medical colleges in India is 299 and of these, 211 colleges are recognized by the Medical Council of India (MCI). The total number of MBBS admissions per year is 32,805 and each year India produces 23,000 new medical graduates. Out of the 299 medical colleges, 225 colleges have postgraduate seats in different specialties with a total number of seats of 12,500. Recently, MCI has proposed an increase in these seats by 5000.

Mental health in India

Mental illness is not a personal failure. It doesn't happen only to other people [3]. Unfortunately, mental health has been neglected for too long, even though it is crucial to the overall wellbeing of individuals, societies and countries. In practice, clinicians rarely address their patients' concerns, beliefs and understanding of illness and seldom share problem management options with them. They limit themselves to simple technical prescriptions, ignoring the complex human dimensions that are critical to the appropriateness and effectiveness of the care they provide [4].

Unfortunately, mental health is not a priority in India and only 2% of the health budget is allotted to it. This is negligible when compared to the escalating healthcare costs and the high cost of drugs for the treatment of mental illnesses. The number of mental health professionals and mental health facilities in India is far less than the required number proposed by WHO. So, also, is the number of rehabilitation centers and half way homes. The facilities made available by the government sector, accessible to the poorer sections of India free of cost, is grossly inadequate. Certainly, the number of facilities in the private sector are increasing rapidly, but these are largely unaffordable for the common man.

India does not have a formal mental health policy, although there is reference to mental health within the national health policy. However, a committee has recently been constituted to draw up a draft National Mental Health Policy, which has started its work with enthusiasm. India does not, at the time of writing, have a substance abuse policy. Some statistics which relate to mental health facilities in India are shown in Box 1 [5].

Box 1 Mental health facilities in India

	(Per 10,000)
Beds	0.25
Beds in mental hospitals	0.2
Beds in general hospitals	0.05
Beds (others)	0.01
Psychiatrists	0.04
Neurosurgeons	0.06
Psychiatric nurses	0.04
Neurologists	0.05
Psychologists	0.02
Social workers	0.02

Positive movements in the field of mental health

Though India has inadequate mental healthcare infrastructure and few mental health professionals, some positive developments have occurred in recent years. A health policy was formulated in 1982 and revised in 2002. India has a list of essential drugs and disability benefits are available. Mental Health Legislation was enacted in 1987 and non-governmental organizations (NGOs) commenced work in advocacy, promotion, prevention, treatment and the rehabilitation of the mentally ill.

A National Mental Health Programme (NMHP) [6] was implemented in 1982. Some of the recent efforts of this programme [7] have been in modernizing mental hospitals, upgrading psychiatric departments in medical colleges, provision of dedicated budgetary support and the implementation of the District Mental Health Program initially in 120 districts and with the aim of

implementation in all 600 districts by 2020 [8]. NMHP was implemented in the 10th Five Year Plan (2002-07). In the 9th plan the budget allocation was only Rupees 26 crores. In the 11th Plan (2007-12) it has increased to Rupees 1900 crores.

For postgraduate courses in psychiatry (MD-Psychiatry and DPM) there are only 300 seats in India. The MCI has suggested a possible enhancement of 125 seats to reduce the gap between the incidence and prevalence of mental illness and the number of professionals available to attend them. Currently, postgraduate courses in psychiatry are available in only 101 of the 299 colleges. The National Human Rights Commission in January 2009 took cognizance of the acute shortage of mental health professionals and directed the MCI to take further steps and to draw up an action plan. Accordingly, MCI has directed that medical colleges applying for postgraduate courses should include psychiatry provision alongside other medical education.

Person-centered medicine in primary care in India

The basic principle of PCM in primary care is an established partnership with patients over time as part of continuity of care, where various illnesses are encountered in the same person, over time. In PCM, the orientation is on patients as individuals, not simply on disease as a single issue. The basic principles of PCM can be implemented only through the integration of mental health into primary care in India and the Indian Psychiatric Society has commenced efforts to achieve such integration.

PCM at the level of the community in India

PCM practised in the community in India aims at personal and patient-oriented care, with continuity of care, care in the family and care in the context of the social environment. The moral principles of PCM in the community are that all patients are considered to be equal and that all are equally entitled to the best care available. Each patient is unique and is to be approached in acknowledgement of their singularity. With a Constitutional amendment, a three tier Panchayati Raj system (local self government) has been established in India. Public care institutions have been brought under Panchayati Raj and this is an opportune moment to incorporate PCM within public health.

Existing biomedical approaches to illness prevention and treatment are inadequate in India. They fail to address the complex relationships between a person's body, mind and social context. Currently, due to a shortage of manpower and time constraints, little opportunity is available for people to receive personalized care, health education, lifestyle counseling and general support. Long term health and happiness is not fostered. PCM focuses on care for the whole person (body, mind and psyche) within the social context, advancing research and professional awareness, compassionate empathy and sense of self. In PCM - oriented community and primary care, people need to be understood holistically, their physical, emotional and social concerns will be addressed in the realities of the world they live in. Hence, the goal of integration of mental health in community with PCM is a comprehensive integrative approach to healthcare.

Education in PCM: the case of Kerala, India

Kerala is the model state for the developing world in the evaluation of PCM. This state provides high quality healthcare at low cost. Kerala is the only state in India with 100% literacy in males with high female literacy also. It is the only State in India where females outnumber males (1058:1000). Most importantly, Kerala has a highly developed social sector and is unique among all other states with health statistics comparable to the developed nations of the World (Kerala State Mental Health Authority- http://www.ksmha.org/). Kerala has the lowest infant mortality rate (11%), lowest maternal mortality rate (<1%) and highest life expectancy (life expectancy males - 73 yrs, life expectancy females -75.5 yrs). Mental health services in Kerala are also far better compared to other states, but have still a long way to go in developing their effectiveness. Kerala has 1 psychiatrist for 100,000 people and although this is inadequate, it is nevertheless three times higher than the national average. Moreover, Kerala also has a large number of general hospital psychiatry units. There are three mental health centers in Kerala.

Conclusion

Education in PCM in India includes participating in person-centered diagnostic developments, preparing educational curricula for person-centered clinical care, integration with general healthcare, training of primary care physicians and integration with the NMHP. Education in person-centered medicine in India needs strengthening. One of the first initiatives should be meaningful undergraduate training in psychiatry. PCM should be part of primary healthcare and it should be an integral part of family medicine. Training lay counselors and social workers and collaboration with NGOs, religious and spiritual leaders will also help propagate the concept of PCM throughout India. "Failure to deal with the whole person in their specific familial and community contexts, misses out on important aspects of health, that do not immediately fit into disease categories" [4].

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