SEA-HMD-216
Distribution: General

# Family Medicine

*Report of a Regional*
*Scientific Working Group Meeting*
*on Core Curriculum*

*Colombo, Sri Lanka, 9-13 July 2003*

WHO Project No.: ICP OSD 002

World Health Organization
Regional Office for South-East Asia
New Delhi
October 2003

This meeting was made possible through the efforts of the Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka, and their excellent support and contribution are gratefully acknowledged.

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# EXECUTIVE SUMMARY

Family medicine is a relatively new area of specialization which evolved in the 1960s in the UK and USA as a felt need in personal health care. Humanistic approaches to health of the whole family, broad-based care of the person rather than focusing on the disease, and improvement of quality of life are some pertinent concerns of the discipline. The family physician now functions as the core of the health care system in many countries.

In countries of the South-East Asian Region, Nepal, Sri Lanka and Thailand have introduced this discipline as a full-fledged specialty, while several others have expressed interest in developing it. The current trend towards specialization with advanced technology, combined with decentralization and community-based care in countries of the South-East Asia Region, has enhanced the need for a specialty that cuts across territorial boundaries of the traditional specialties in order to promote primary care in the district health system.

The Scientific Working Group Meeting for the Development of a Core Curriculum in Family Medicine for the South-East Asia Region was held in Colombo, Sri Lanka, from 9 to 13 June 2003. Twenty-seven representatives from 7 countries in the Region, including specialists in family medicine / general practice, specialists in medical education, decision makers in universities and ministries of health, and representatives of national medical associations or medical councils, participated in the meeting.

The main objectives of the meeting were:

(1) To identify the status of family medicine and general practice as an academic discipline in Member Countries;

(2) To formulate basic principles for a core curriculum in family medicine at undergraduate and specialist levels, and

(3) To recommend specific mechanisms for promotion of family medicine programmes.

Representatives from each participating country presented the current status of training in family medicine at both undergraduate and postgraduate levels. Group discussions focussed on core curricula for three levels of practices: basic medical education; intermediate diploma level of post-graduate specialization; and full specialist level.

Although several countries in the region do not have separate departments of family medicine in their medical schools, it was agreed that basic medical graduates must have several competencies that fall within the domain of family medicine. Thus, the core curriculum for family medicine was defined in such a way that it could be achieved through currently existing structures. Learning objectives relevant to the discipline of family medicine and the core content areas were identified. Recommendations were made regarding the sequence of teaching, teaching-learning methods, and methods of assessment.

For post-graduate education at intermediate level, at present the period of training is 1 – 2 years in Bangladesh, India, Myanmar, Sri Lanka and Thailand. Flexibility in the duration and nature of the training programme was strongly recommended, based on the variable nature of employment for prospective candidates. Recruits should have a basic medical degree and a license to practice medicine from the national licensing authority. Recommendations were made regarding the competencies expected at this level of specialization, the relevant content areas that should be included in the training programme, and the procedural skills that should be mastered, as well as teaching-learning methods and assessments.

Specialist qualifications in family medicine are usually awarded after a three-year training programme, i.e. at par with other medical specialties. It was recommended that training programmes should include full-time clinical training as well as submission of a dissertation. Recommendations were made regarding the competencies expected at specialist level, the relevant content areas that should be included in the training programme, and the procedural skills that should be mastered, as well as teaching-learning methods and assessments.

The Scientific Working Group made the following recommendations in order to strengthen undergraduate and post-graduate training in family medicine in the Member Countries of the South-East Asia Region:

### *To Member Countries*

(1) Family Medicine should be recognized as a separate speciality in medicine;

(2) Immediate steps should be taken to incorporate the recommended core curriculum in family medicine into the existing basic medical curriculum;

(3) Departments of family medicine should be established whenever and wherever possible;

(4) Provision should be made for training of teachers for family medicine;

(5) Post-graduate specialization in family medicine should be established wherever possible, and

(6) Appropriate structures and cadres should be developed for incorporating general practitioners and trained family physicians within the national health system.

### *To WHO*

(1) To support strengthening of the capacity to establish family medicine as a specialty in training institutions in Member Countries;

(2) To support countries to build their capacity in teacher training in family medicine;

(3) To facilitate development of a regional network and accreditation of Family Medicine training programmes, and

(4) To support strengthening of the health care services in Member Countries including primary health care, by incorporating family medicine in the national health systems.

# 1. INTRODUCTION

Family medicine is defined as that specialty of medicine which is concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioural and social sciences. As an academic discipline, it includes comprehensive health care services, education and research. A family doctor is a physician who is a specialist trained to provide health care services for all individuals, regardless of age, sex or type of health problem. A family doctor provides primary and continuing care for entire families within their communities; addresses physical, psychological and social problems; and coordinates comprehensive health care services with other specialists as needed. Family doctors may also be known as family physicians or general practitioners, depending on the location of practice.

Family practice is a relatively new area of specialization. The concept of this discipline evolved in 1960s in the UK and USA. In USA, family medicine evolved from general practice as a felt need in personal health care. In UK, the same trend has been noticed in the introduction of a general practice as a specialty of the Royal College of general practitioners with systematic training programmes on par with the MRCP and FRCS fellowships.

The family physician constitutes the fundamental core of the health system in the Netherlands and Spain. The general practitioner is the key provider in National Health System in the UK. Recently EEC has defined the duration of post-graduation training in general practice. In Cuba, the family physician is the chief provider in their comprehensive health plan. Family practice is also active in South Korea, Malaysia and Singapore. The nature of care varies from country to country, and may even involve an active role in hospital care. Thus the nature of the curriculum of training programmes in family medicine, the time duration, and the ratio of preventive / curative care also varies from country to country.

Humanistic approaches to health of the whole family, broad-based care of the person rather than focus on the disease, improvement of quality of life are some pertinent concerns of the discipline. Realizing the essential role of family physicians in health care system, the international group uniting this specialty, the World Organization of National Colleges, Academies and Academic Association of General Practitioners and Family Physicians

(WONCA) or, the World Organization of Family Doctors, works in collaboration with WHO to improve global health systems by the integration of family medicine.

In countries of the South-East Asian region, Sri Lanka (Family Medicine), Thailand (Family Medicine) and Nepal (General Practice) have introduced this discipline as full-fledged specialties. A specialized programme in general practice was introduced several years ago in the Christian Medical College, Vellore, India. This programme is yet to be recognized by the Medical Council of India. The Indonesian Medical Association has developed initiatives to strengthen Family Medicine in their academic programme.

The current trend in specialization with advanced technology, decentralization and community-based care in countries of the SEA Region further underscores the need to cut across territorial boundaries of all traditional specialties with varied clinical skills to promote primary care in the district health system.

The specific objectives of the meeting were:

(1) To identify the status of family medicine and general practice as an academic discipline in Member Countries;

(2) To formulate basic principles for a core curriculum in family medicine at undergraduate and specialist levels, and

(3) To recommend specific mechanisms for promotion of family medicine programmes.

## 2. INAUGURAL SESSION

In his welcome address, **Dr P T Jayawickramarajah**, Coordinator, Strengthening Health Systems Delivery, World Health Organization, South East Asia Regional Office, stressed the importance of the meeting in the context of developing health systems. He said that the performance of health systems was being measured not only in terms of health indices, but also in terms of their responsiveness to the needs of the country. In this context, moving towards the development of comparable training programmes for general practitioners and family physicians at different levels of specialization was most important.

The inaugural message of **Dr Uton Muchtar Rafei**, Regional Director, WHO/SEARO, was read out by **Dr Lokky Wai**, Acting WHO Representative, WHO Colombo. The message highlighted the role of the family physician in the context of improving primary health care. Family practice is a broad speciality which builds upon a core of knowledge derived from other disciplines- drawing extensively from internal medicine, paediatrics, obstetrics and gynaecology, surgery and psychiatry, along with public health and behavioural disciplines. Family medicine recognizes the importance of interaction between the patient and physician and its effects on patient outcomes and satisfaction. It has increased our understanding of family dynamics and how to treat individuals in the context of their families. The Regional Director also highlighted the role played by WHO in capacity building in the Region for development of this specialty education. However, only a few countries in the Region – Sri Lanka, Thailand and Nepal – have full-fledged specialized programmes for general practice or family medicine. A few other countries have already taken preliminary steps to initiate family medicine as an academic discipline. WHO has also facilitated efforts by the World Organization of Family Doctors (WONCA) to promote primary health care through family physicians.

In a globalizing world, with doctors migrating across countries, there is a need for equivalence of qualifications and comparable educational programmes. The Regional Director wished that the discussions would cover issues relating to the knowledge and skills to be acquired by doctors in the new specialty of family medicine, and asked the participants to review and think about the role of family practice in fostering better care through skilled knowledge.

**Dr Palitha Abeykoon**, Temporary Advisor, WHO Colombo, spoke of the developments that have taken place in the South-East Asian Region in the recent past in relation to the development of family medicine. Organized change took place after the 1970s with articulation of the concepts of Reorientation of Medical Education (ROME) and Primary Health Care (PHC). These resulted in fundamental changes in the way doctors and other medical professionals were trained. He stressed that changes could not be confined to training alone, but needed to be reflected in the health system, and in medical practice in order to have maximum impact.

**Dr Reggie Perera**, Secretary, Ministry of Health, Nutrition and Welfare, spoke of the joint delivery of health care in Sri Lanka by the public and

private sectors. He stressed the need to motivate young doctors to go into full-time family practice. Noncommunicable diseases that are related to lifestyle, now dominate the morbidity pattern in Sri Lanka. Management of many of these diseases require lifelong treatment, and family physicians have a particularly important role in this context.

**Prof Lalitha Mendis**, Director, Post-Graduate Institute of Medicine (PGIM), University of Colombo, said that the nuclear family unit is the backbone of any country. Looking after the health of this unit is of paramount importance. Over the last few years, medical schools in Sri Lanka have changed their undergraduate curricula and fitted in family medicine in different ways to suit the medical school best, in terms of their setting, and the available resources. Development of a core curriculum in family medicine, however, would help to ensure that this is done in a manner that maintains comparability. The PGIM had two levels of training: the Diploma and the MD in Family Medicine. It was not a mandatory requirement that family practitioners in Sri Lanka should have specialist qualifications, but working towards this goal would help to improve the quality of care. However, consideration of the most appropriate method of delivery of training was of great importance, because most family physicians were in private practice, and could not afford to enter full-time training programmes. She also requested the policy-makers to develop a long-term plan to strengthen family practice in the country.

**Prof K Tillekeratne**, Vice-Chancellor, University of Kelaniya, the host collaborating institution for the meeting, welcomed the participants. He highlighted the contributions made by University of Kelaniya in developing the specialty of family medicine.

**Mr P Dayaratna**, Honourable Minister of Health, Nutrition and Welfare, spoke of the gains made in improving the health of Sri Lankans. He stated that family physicians played a very important role in this health system, but deplored the lack of a well-established referral system. This had resulted in under-utilization of the smaller, rural hospitals and over-crowding of the bigger urban hospitals. The government was considering bringing in the active involvement of private sector practitioners to support state services in rural areas.

**Dr M Khalilullah**, Regional Fellowships Officer, SEARO, delivered the vote of thanks.

## 3. SUMMARY OF KEY PAPERS

**Prof Shatendra K Gupta**, in his presentation on "The role of WONCA in the development of Family Practice" described the constitution of WONCA (World Organization of Family Doctors), its mission, the people who run WONCA, the work done by the organization, including its relations with other bodies. He described the organization's policy on training for rural general practice. The worldwide shortage of rural family doctors contributes directly to the difficulties in providing adequate medical care in rural and remote areas in both developed and less developed countries. WONCA believes that there is an urgent need to develop strategies to implement rural health services around the world. This will require sufficient numbers of skilled rural family doctors. Its recommendations for achievement of this goal as well as views with regard to setting up a Department of Family Medicine in a medical school, and the fundamental tasks involved were presented. The need to attract students to careers in family medicine was emphasized. It was stated that WONCA wishes to encourage and support the development of academic organizations of general practitioners / family physicians in the Middle East and South Asian Region, especially in Bangladesh and India.

**Dr M Khaliullah** described the role of general practice in the health care system, particularly in the context of primary health care. Since its inception, WHO has emphasized the need for development and strengthening of the health systems of Member Countries. It is mandated, through its constitutional provision to, among other, strengthen health services, provide technical cooperation / assistance, enhance cooperation among the scientific and professional groups, promote improved standards of teaching and training in health, medical and related professions and set standards and norms within the health care programmes. With regard to advocacy support, he recommended that family practice should be in-built within the national health policy. He emphasized the stewardship role of the government in regulating and supporting health delivery. In relation to technical support for curriculum development in family medicine, he suggested that the family medicine curriculum should be integrated with the basic curriculum for medical studies at undergraduate and postgraduate levels. WHO may consider strengthening the College of General Practitioners of each Member Country, through development of guidelines and modules, training of teachers, supply of relevant research materials and publications, and some

essential logistics. He observed that periodic follow up by WHO on the status of family practice, review of the performance of the colleges, and also the evaluation of family practice in selected countries would be very useful.

**Dr P T Jayawickramarajah**, in his presentation on "Family Medicine in national health systems" recalled the role of family physicians and general practitioners in the health care system, particularly in the Member Countries of the Region. He noted that it was still not recognized or established as a distinct medical specialty in many countries of the Region. For any area of service to contribute to new knowledge, such an area must be recognized as a discipline. However, such an additional discipline should not dictate the nature of training of basic medical education; rather the objectives of basic medical education should define the scope and extent of coverage of family medicine in their curriculum. However, the education of a family physician is unique in terms of its focus on training away from hospital settings, with multidisciplinary input and the use of cost-effective methods. In health systems, increasing globalization has resulted in the need to move towards standardization of training programmes and services. Thus while the focus of training family physicians should be community-based according to the needs of the country, core competencies must be identified, in order to train family doctors who would be able to practise anywhere in the world.

**Dr A Kesanna**, in his presentation on "Role of Professional Associations in Family Medicine", said that 70% of qualified medical graduates in India practised as family physicians, but there were no recognized specialists in family medicine, except for about 90 Diplomats of the National Board (Family Medicine). The professional associations in India therefore had a great responsibility to work in close coordination with the various statutory bodies and governments to promote training programmes in family medicine. He outlined the main areas in which this should be done: liaison with the government of India and with state governments; incentives that should be provided to family medicine specialists to encourage them to go to rural areas; action to be taken by the Medical Council of India and by Universities; interactions between professional associations; and the role of the IMA College of General Practitioners and the National Board of Examinations. The need for sensitization of the medical fraternity and to raise awareness among the general public, along with the possible role of health insurance schemes, was also highlighted.

**Prof Nandani de Silva**, in her presentation on "Current status of educational programmes in Family Medicine in different countries", spoke of training programmes in family medicine conducted in the UK, USA and Australia, as well as Bangladesh and Sri Lanka. The renaissance in family medicine / general practice started in the middle of the 20th century, when the UK launched its first vocational training programme in 1951. By the 1980s educational programmes in family medicine were also being conducted in other European countries, the USA and Canada, in Australia and New Zealand, as well as in the Asian countries of Singapore, Malaysia, the Philippines, Sri Lanka and Nepal.

Most of the undergraduate programmes in Family Medicine in these countries are now conducted in the third, fourth and final year, while in some schools, the programme extends through all years of study. The teaching-learning methods include lectures, seminars and tutorials to cover common clinical problems and the behavioural sciences; training in communication skills: clinical skills teaching and learning sessions, and clerkship rotations to University Family Medicine centres and GP preceptors in the community for periods ranging from 2 - 6 weeks or more. In UK, the National Health Service vocational (postgraduate) training programme for general practice is conducted through deaneries in different regions. The training is conducted in hospital posts and under GP trainers recognized by the Joint Committee on Postgraduate Training for General Practice (JCPTGP). At the end of the period of training doctors have to pass the summative assessment. The JCPTGP gives a certificate of prescribed experience to those who have successfully completed the training programme and passed summative assessment, which is the license to practice as a GP in the UK.

In USA, residency training programmes are conducted by university departments of family medicine. The Board examination is conducted by the American Board of Family Physicians and those who pass are Board certified as specialists in family medicine for seven years. To retain Board certified status, they have to take the Board examination again.

In Australia, the vocational training programme is conducted by the Royal Australian College of General Practitioners (RACGP). The Department of General Practice of Monash University also conducts a postgraduate course towards a Diploma and a Masters in Family Medicine through distance education.

Singapore, Malaysia, Phillipines and Pakistan have residency programmes conducted by university departments of family medicine in collaboration with the Department of Health. In Bangladesh, postgraduate courses in family medicine are conducted by the University of Science and Technology, Chittagong, the Bangladesh College of General Practitioners and the Bangladesh Academy of Family Physicians. In Sri Lanka, all medical postgraduate training including family medicine are conducted by the Postgraduate Institute of Medicine, University of Colombo. The Board of Study in Family Medicine has representatives from all the universities and the College of General Practitioners of Sri Lanka.

In most countries, doctors registered with the country's medical council for independent practice are eligible to follow the training programme. Some countries specify a number of years after registration prior to eligibility. The postgraduate training programmes in UK, USA and Australia, are all of three years' duration. The structure and duration of different training programmes, their learning objectives, teaching-learning methods and course contents, the resources made available to course participants, the methods of assessment, and programme evaluation were also explained.

## 4. TECHNICAL SESSIONS

**Prof Sham Sunder** (India) was nominated as Chairman and **Prof Maung Maung Wint** (Myanmar) as Vice-Chairman. **Dr Nitaya Wonsangiem** (Thailand) and **Prof Nilanthi de Silva** (Sri Lanka) were nominated as rapporteurs.

### Country Reports

Representatives from each participating country presented their current status with regard to training in family medicine, at undergraduate and postgraduate levels. These are presented in summary form in Table 1.

***Table 1.*** *Summary of current training programmes and qualifications in family medicine in SEAR countries*

| Country | Qualification | Awarding Institute | Level of training | Years of training | Entry criteria | Course work in Family Medicine | Separate Examination in Family Med |
|---|---|---|---|---|---|---|---|
| Bangladesh | MBBS | Medical schools | Undergraduate | 5 yr.+ One year of internship | As for medical schools | Incorporated in Community Medicine curriculum | No |
| | Fellow of College of General Practitioners (FCGP) | Bangladesh College of General Practitioners | Postgraduate (intermediate) | One year | MBBS degree and registration with BMDC<br>5 years experience, including 3 years in family practice<br>Member of BPMPA | Yes | Yes |
| | Family Medicine Diploma (FMD) | University of Science and Technology, Chittagong | Postgraduate (intermediate) | One year | MBBS degree and registration with the BMDC | Yes | Yes |
| | Member of the College of Physicians and Surgeons (MCPS) | Bangladesh College of Physicians and Surgeons | Postgraduate (intermediate) | No organized course | MBBS degree and registration with the BMDC<br>4 years' experience, after graduation | None | Yes |

| Country | Qualification | Awarding Institute | Level of training | Years of training | Entry criteria | Course work in Family Medicine | Separate Examination in Family Med |
|---|---|---|---|---|---|---|---|
| India | MBBS | Medical schools | Undergraduate | 5 ½ including one year of internship | As for medical school (10 + 2 years of schooling; 17 years of age) | Incorporated in clinical and community medicine curricula | No |
| | Fellow of the Indian Medical Association College of General Practitioners (FIMACGP) | Indian Medical Association College of General Practitioners | Postgraduate (intermediate) | One year | MBBS degree and registration with MCI Life membership of IMA and IMACGP Registration one year | Self study and credit hours from CME programme | Yes |
| | Diplomate of National Board (Family Medicine) [DNB (Family Medicine)] | National Board of Examination (NBE) under MOH | Postgraduate (specialized) | 3 years | MBBS degree | Training in an institute or in Family Medicine, recognized by NBE | Yes |
| | Others: DFM and MD (FM) | Univ. of Colombo in association with IMACGP<br>Tribhuvan Univ, in association with CMAI | Postgraduate Intermediate and Specialist | 3 years | As for the Sri Lankan and Nepalese degree courses | Yes | Yes |

| Country | Qualification | Awarding Institute | Level of training | Years of training | Entry criteria | Course work in Family Medicine | Separate Examination in Family Med |
|---|---|---|---|---|---|---|---|
| Indonesia | B. Med. | Medical schools | Undergraduate | 4 years | As for medical school | Incorporated in clinical and community medicine curricula | No |
| | MD | Community, clinics and hospital | Professional | 2 years clerkship | B Med. | None | No |
| | Masters in Family Medicine | University | Postgraduate (Academic) | 2 years | M D | Yes | Yes (defend thesis) |
| Myanmar | MBBS | All medical institutes | Undergraduate | 4 years and one year of internship | As for medical school | Incorporated in clinical and community medicine curricula | No |
| | Diploma in Medical Sciences (General Practice) To be replaced by Family Medicine Diploma | All medical institutes | Postgraduate (Intermediate) | 1 year | Completion of 3 years' government service in community hospital | Complete full-time course | Yes (summative at the end of the course) |
| | Diploma in Medical Sciences (Family Medicine) Scheduled to replace General Practice Diploma | All medical institutes | Postgraduate (Intermediate) | 1 year | As for other postgraduate exams | Structured modular course | Yes (summative at the end of the course) |

| Country | Qualification | Awarding Institute | Level of training | Years of training | Entry criteria | Course work in Family Medicine | Separate Examination in Family Med |
|---|---|---|---|---|---|---|---|
| Nepal | MBBS | Medical Schools | Undergraduate | 5½ years including one years internship | As for medical school | Yes | Yes |
| | MD (General Practice) | Tribhuvan University | Postgraduate (Specialist) | 3 years | MBBS<br>One year experience<br>Entrance examination | Yes | Yes |
| Sri Lanka | MBBS | Medical schools | Undergraduate | 5+ and one year internship | As for medical school | In clinical depts. Or depts. of Community & Family Medicine | No |
| | Diploma in Family Medicine (DFM) | Postgraduate Institute of Medicine, University of Colombo | Postgraduate (intermediate) | 1 year | MBBS or equivalent<br>Registration with SLMC<br>One year clinical experience<br>Qualifying examination | Yes | Yes |
| | MD (Family Medicine) | Postgraduate Institute of Medicine, University of Colombo | Postgraduate (specialist) | 3 years | DFM + 3 years' active professional experience in General / Family Practice, during 10 years preceding date of application | Yes | Yes<br>(or defend thesis) |

| Country | Qualification | Awarding Institute | Level of training | Years of training | Entry criteria | Course work in Family Medicine | Separate Examination in Family Med |
|---|---|---|---|---|---|---|---|
| Thailand | MD | Medical schools | Undergraduate | 6 years | As for medical school | Yes, Dept of Family Medicine | Yes |
| | Diploma in Clinical Sciences (Family Medicine) | Chiangmai Univ. and Thammasat Univ. | Postgraduate (intermediate) | 1 year | MD<br>01 year of internship | Yes | Yes |
| | Diplomate Thai Board of Family Medicine (FCFPT) | Thai Medical Council and College of Family Practitioners of Thailand | Postgraduate (specialist) | 3 years | MD + 1 – 3 years' clinical experience | Yes | Yes |

### *Bangladesh*

**Prof A K M Shariful Islam** described the nature of family / general practice in Bangladesh and outlined its current educational programmes for training family physicians and general practitioners. A new curriculum that incorporates a family medicine curriculum within the community medicine curriculum would be introduced in the MBBS course during the 2002 – 2003 session. Three postgraduate qualifications relating to family medicine were recognized in Bangladesh: Fellow of the College of General Practitioners (FCGP), Family Medicine Diploma (FMD) and Member of the College of Physicians and Surgeons (MCPS).

### *India*

**Prof B K Jain** summarized the nature of training in family medicine in India. The undergraduate curriculum did not include a specific family medicine component. Indian institutions offered two postgraduate qualifications: the Fellowship of the Indian Medical Association College of General Practitioners (FIMACGP) and Diplomate of the National Board of Examinations (Family Medicine). Only the latter was recognized as a specialist qualification by the Indian Medical Council. Other qualifications were offered in conjunction with foreign institutions: the Diploma in Family Medicine was offered by the PGIM of the University of Colombo Sri Lanka, in conjunction with the IMACGP, and the MD (General Practice) was offered by Tribhuvan University, Nepal in conjunction with CMAI.

### *Indonesia*

**Prof Amal Sjaaf** presented the situation with regard to Indonesia. The undergraduate curriculum did not include specific training in family medicine, but relevant areas were taught in the clinical subjects, and management and administrative competencies in community medicine during the last two years clerkship. The only relevant postgraduate qualification was the Master of Family Medicine (MFM), which was an academic, rather than specialist qualification.

### *Myanmar*

**Prof Myo Myint** described the situation with regard to Myanmar. The undergraduate curriculum did not include specific training in family medicine, but relevant areas were taught along with teaching in behavioural science, in preventive and social medicine, and through field training and during

internship, through a two-week programme of residential field training. At present, there was one relevant postgraduate qualification, the Diploma in Medical Science (General Practice). This was to be replaced in the near future, by the Diploma in Medical Science (Family Medicine), which was a structured, modular course, offering greater flexibility in training than the previous programme. Both programmes were of one year duration.

### *Nepal*

**Prof Gopal Acharya** and **Dr Manohar Gupta** described the undergraduate and postgraduate training programmes in general practice conducted in Nepal. The three-year MD (General Practice) programme offered by the Tribhuvan University was developed in conjunction with the University of Calgary, Canada, commencing in 1982. Its goal was to produce specialists who were able to provide comprehensive and effective management of common health problems encountered in rural Nepal, including timely, emergency and life-saving surgical and obstetric interventions. The training programme focused on skills development through extensive use of rural hospitals. The clinical rotation in the first year concentrated on the medical specialties (general medicine, paediatrics, psychiatry and dermatology); in the second year, on the surgical specialties (general surgery, obstetrics & gynaecology, family planning, orthopaedics, eye and ENT). In the third year, trainees underwent rotations in a district hospital, in emergency, anaesthesia, and dental surgery, and forensic medicine. The summative examination conducted at the end of the training programme included a written theory component, as well as oral and clinical components.

### *Sri Lanka*

**Prof Leela Karunaratne** described the undergraduate and postgraduate training programmes in family medicine in Sri Lanka. Two of the six medical schools had full time staff dedicated to teaching family medicine, with formal instruction and assessment of students in family medicine. Since 1981, the Post Graduate Institute of Medicine of the University of Colombo offered two courses through its Board of Study in Family Medicine: a one-year programme leading to the Diploma in Family Medicine, and a three-year programme leading to the MD (Family Medicine). At present, the MD could be obtained in one of two ways: by following a training programme with summative examination, or by submitting a thesis on research done on a topic relevant to family medicine, and defending it at an oral examination. This latter method was being phased out.

### *Thailand*

**Dr Nitaya Wongsangiem** described training programmes in family medicine, conducted in Thailand, at undergraduate and postgraduate levels. Most of the 13 medical schools had Departments of Family Medicine, with formal instruction in the discipline, for students in their fourth and fifth years of study. Some medical schools had training in the sixth year as well. Postgraduate training in general practice was started in 1973, but this programme was not successful in that few doctors took it up, and most Diplomates practised either in hospitals or private clinics in Bangkok and other big cities. This programme was being replaced by the Diplomate in Family Medicine programme under the Thai Medical Council (TMC) and the College of Family Physicians of Thailand (CFPT). This latter programme consisted of on-the-job training in various settings such as family practice clinics, hospital rotations in medical and surgical specialities, workshops that focused on the concepts of family medicine, and research in primary care. Evaluation of trainees on this three-year programme included formative evaluation in each rotation, summative evaluation at the end of each academic year, and at the end of the programme. Some training institutions such as Thammasat and Chiangmai Universities also offered a one year Diploma programme in Family Medicine.

The participants in the meeting agreed that a core curriculum in family medicine for the region should be developed at three different levels.

(1) Basic medical education: Although several countries in the Region did not have separate departments of family medicine in their medical schools, it was agreed that basic medical graduates must have several competencies that fall within the domain of this discipline. Thus, the core curriculum was defined in such a way that it could be achieved through currently existing structures.

(2) Postgraduate education, intermediate level: These qualifications were awarded after one– two years of training, for example, FCGP and FMD in Bangladesh, FIMACGP in India, Diploma in Medical Sciences (Family Medicine) in Myanmar, and DFM in Sri Lanka, Thailand.

(3) Postgraduate education, specialist level: These qualifications were usually awarded after a three-year training programme. E.g. DNB (Family Medicine) in India, MD (General Practice) in Nepal, MD (Family Medicine) in Sri Lanka, and Diplomate of the Thai Board of Family Medicine in Thailand.

# 5. CURRICULULM FOR FAMILY MEDICINE

## 5.1 Core Curriculum for Undergraduates

### *Learning objectives*

The broad learning objectives listed below are related to family medicine, and are relevant to any country in the Region. These learning objectives include communication skills, contextual clinical skills, procedural skills and managerial skills.

A basic medical graduate should be able to:

(1) Provide primary care, which is personalized, comprehensive and continuing;

(2) Provide holistic care to the individual, family and community;

(3) Establish a good doctor-patient relationship, show empathy, communicate effectively, educate, advice and counsel appropriately;

(4) Recognize psychological, social and cultural influences on health and health-seeking behaviour;

(5) Diagnose and manage common symptoms and common medical, surgical and psychosocial problems in patients of all ages and both sexes, with special emphasis on the child, the adolescent, the woman and the elderly;

(6) Recognize the interdependent roles of physician experience, patient preferences and best available evidence in clinical decision-making;

(7) Provide initial emergency care including first aid measures, CPR and refer when necessary, using appropriate means of transportation;

(8) Request appropriate investigations and practise cost-effective management with rational drug prescription;

(9) Promote health and prevent diseases at every opportunity and support / cooperate with the implementation of national health programmes;

(10) Identify conditions that need referral and refer appropriately to coordinate the patient's health care;

(11) Provide care and counselling for the elderly, terminally ill and bereaved;

(12) Carry out home visits and home-based care;

(13) Recognize problems affecting people at different stages of the life cycle;

(14) Recognize normal and abnormal relationships within the family, and how they affect a family in health and illness;

(15) Recognize and manage occupational and environmental health problems;

(16) Practise within the ethical norms required of a medical practitioner with due respect to the autonomy of the individual and family and attention to confidentiality, informed consent etc;

(17) Write complete, accurate, organized and focussed medical records;

(18) Issue medical certificates and manage medico-legal problems;

(19) Practise management and leadership skills;

(20) Engage in life-long learning and continuing professional development;

(21) Recognize the importance of quality assurance and practise guidelines;

(22) Inculcate a scientific inquiring mind and investigate to solve problems; carry out research in primary medical care.;

(23) Share knowledge with colleagues, students and other health workers, and

(24) Act as a friend, philosopher and advisor to the family of the patient.

### *Content areas*

(1) Principles, concepts and scope of family medicine;

(2) The family structure, family function, family life cycle and influence of family on illness and illness on the family, family resources, family therapy; stressful life events and family crises;

(3) Introduction to behavioural and social sciences relevant to family practice: psychological, social and cultural effects on health, illness behaviour and the sick role;

(4) The consultation and doctor-patient relationship;

(5) Hypothetico-deductive method of diagnosis and clinical reasoning style;

(6) Management of:

- Common symptoms/illnesses in family practice
- Psychosocial problems
- Chronic diseases
- Common emergencies

(7) First aid, CPR, transportation of patients;

(8) Basic laboratory investigations, techniques, interpretation;

(9) Essential drug list, rational prescribing and prescription writing;

(10) Referral;

(11) Health promotion and disease prevention: screening and medical examination for physical fitness, nutrition;

(12) Introduction to geriatrics, and care of the elderly;

(13) Caring for the ill person at home;

(14) Communication skills, counselling skills, breaking bad news, palliative care, bereavement;

(15) Documentation of medical information, medical records in family practice;

(16) Ethical and legal issues in family practice;

(17) Teamwork practice, management and leadership skills: clinical audit, quality assurance, introduction to health economics;

(18) Life-long learning, information retrieval, and continuing professional development;

(19) Health education of individual and family, and

(20) Health of the doctor and his / her family.

### *Sequence of teaching and teaching learning methods*

Learning experiences should be spread through the entire period in medical school, from first to final year. An appropriate combination of the following teaching-learning methods is recommended for undergraduate training programmes.

(1) Classroom teaching with lectures, small group discussions, journal review and seminars as well as presentations on common case scenarios;

(2) Clinical training through rotations to academic family medicine centres, GP clinics in the community and home visits;

(3) Other activities such as maintaining log books, case study write-ups, compilation of portfolios, and clinico-social case studies;

(4) A research project. and

(5) Internship with a minimum duration of one month.

### *Assessment*

Formative assessments, particularly in relation to communication skills and procedural skills, may be conducted during clinical rotations.

Summative assessments may take the form of a separate examination in family medicine or form part of the examinations in clinical subjects (medicine, surgery, obstetrics & gynaecology, paediatrics, psychiatry) and in community medicine, with allocation of a specified percentage of these marks for family medicine.

The examination format may include theory questions (multiple choice questions, modified essay questions and / or structured essay questions), an oral examination, and clinical examination, including an Objective Structured Clinical or Practical Examination (OSCE or OSPE).

## 5.2 Core Curriculum for Postgraduates (Intermediate Level)

### *Entry criteria*

(1) Basic medical degree and internship with license to practice medicine

(2) The period of clinical experience after internship will depend on country regulation and other medical courses

### *Course duration*

Taking into consideration the nature of employment of prospective candidates, there must be flexibility in the nature of the training programme. This may vary from a one-year, full-time, residential programme to a two- to three-year, part-time programme.

### *Competencies*

The training provided to the candidates will enable them to provide a higher level of comprehensive and continuous health care in the family practice setting. Diploma holders are expected to have the following competencies in:

(1) Dealing with emergencies, giving proper first aid based on best evidence, coordinating consultation with appropriate referral and transportation;

(2) Effective management of common diseases prevalent in the locality of the family practice, either presenting with common or wide range of common/bizarre symptoms;

(3) Acknowledging the importance of and practising personalized, comprehensive care with continuity, using a holistic approach;

(4) Effective communication with patients, family, colleagues and other health care worker, and community;

(5) Applying knowledge of behavioural and social sciences in the patient management plan, respecting the autonomy, dignity and rights of the patient/family;

(6) Promoting health, organizing preventive care measures and supporting the national health programmers;

(7) Practising cost-effective management with knowledge in health economics;

(8) Practice management with managerial skills including medical record keeping, auditing, coordination within the health service system and recognizing the importance of quality assurance;

(9) Critical appraisal of medical information presented in the literature and by pharmaceutical firms;

(10) Applying research method to undertake needs-based research in the community;

(11) Medical ethics and law with ability to handle medico-legal issues and maintain professional ethical standards, and

(12) Self directed lifelong learning and continuous professional development.

### *Content*

The following areas are suggested as suitable contents for this level of training. Modifications may be required to suit each country's context.

(1) Common symptoms such as musculo-skeletal pain, chest pain, fever, headache, fatigue, jaundice, common cold, dyspnoea, giddiness, depression etc.

(2) Handling emergencies such as injuries, shock, myocardial infarction and cerebro-vascular accidents, coma, fits, asthma, poisoning, snake bite, diarrhoea (fluid and electrolyte disturbances) etc

(3) Preventive care services such as immunization, well baby care, well-lady clinic, family planning, healthy life style, mental health

(4) Practice management: auditing, recording, HSR, ethics and law

(5) Procedural skills

- *Medicine*: cardio-pulmonary resuscitation, lumbar puncture, pleural aspiration, peritoneal aspiration, drainage of tension pneumothorax; nasogastric intubation and lavage; intravenous, intramuscular, subcutaneous, intradermal and intralesional injections
- *Obstetrics & Gynaecology*: conduct of normal delivery, making and suturing of episiotomy, management of breech delivery and retained placenta; speculum examination, cervical smear, IUCD insertion
- *Ophthalmology*: funduscopy, removal of foreign bodies
- *Orthopaedics*: Splinting of fractures, reduction of simple fractures and dislocation
- *Otolaryngorhinology*: removal of foreign bodies from nose, syringing of ear, nasal packing
- *Pathology*: Haemoglobin level, erythrocyte sedimentation rate, total and differential leukocyte count, blood picture for malaria parasites and anaemias, routine and microscopic examination of urine and stool, microscopy of urethral and vaginal discharge, blood sugar with glucometer.
- *Surgery*: assessment and closure of traumatic wounds, incision and drainage of abscess, excision and biopsy of superficial swellings, venesection, urethral catheterization, suprapubic cystostomy, circumcision in adults, tracheostomy, intercostal tube drainage.

### *Teaching-learning methods*

The following teaching-methods are suggested for training at this level

(1) Clinical training through rotations in general practice, medicine, paediatrics, surgery, obstetrics & gynaecology, ophthalmology, otolaryngorhinology, and orthopaedic surgery.

(2) Lecture-demonstrations, group discussions, seminars,

(3) Maintenance of a log-diary, compilation of portfolio, project work

### *Assessment*

The summative examination at the end of the period of training may consist of the following elements:

(1) Theory questions in the form of multiple choice questions and modified essay questions

(2) Clinicals: long and short consultation in family practice,

(3) OSCE/ OSPE

(4) Viva voce (on a log diary, portfolio)

(5) ADI (Assessment Driven Instruction)

## 5.3 Core Curriculum for Postgraduates (Specialist Level)

### *Entry criteria*

(1) Basic medical degree with internship and license to practice medicine

(2) Other criteria may be determined on the basis of entry criteria for other postgraduate MD courses in the country concerned

### *Course duration*

(1) A three-year full-time course involving clinical training and a dissertation is recommended. Candidates having intermediate level postgraduate qualification in family medicine may be allowed to complete the course in two years.

(2) Other regulations on the duration of training may be determined according to other post-graduate MD programmes in the country.

(3) Exemption from specific training components (for a maximum of six months to one year) may be given according to the regulations of the regulatory authority.

### *Competencies*

The following competencies listed for the diploma should be acquired in greater depth.

(1) Effective management of common diseases within the limited resources of family practice setting.

(2) Identification of complex health problems and appropriate referral

(3) Promotion of health and prevention of disease, and support of the national health programmes

(4) Ability to care for disadvantaged groups in the community such as the elderly, mentally and physically handicapped persons

(5) Demonstration of knowledge of behavioural science related to family practice

(6) Effective communication with patients, family, colleagues and other health care workers, and community

(7) Domiciliary care and palliative care

In addition to those listed above, the following competencies must also be acquired during the specialist level training:

(1) Ability to conduct research, and submit it in the form of a dissertation;

(2) Computer literacy in respect of patient management, search for medical information and use of statistical packages for analysis of data;

(3) Ability to teach and supervise undergraduates, postgraduates and other levels of para-medical staff;

(4) Ability to manage a wide range of common medical emergencies in the context of family practice with evidence-based medicine;

(5) Ability to make decisions regarding the need for, and the appropriate and cost-effective use of, modern technological investigations and ability to interpret the results of these investigations;

(6) Demonstrate managerial skills, develop ability to work in a team with good leadership skills;

(7) Development of a critical mind and the ability to solve patient problems within a particular sociocultural setting, harnessing available community services

(8) Ability to maintain a good medical recording system, with particular regard to a defined community, making use of tools such as family genogram etc

(9) Being a role model in health behaviour, and the ability to organize and actively engage in community care programmes, focusing on promoting and maintaining health of the community including dental health care

(10) Development in a particular area of expertise in family medicine and contribute to new knowledge e.g., counselling for psychosocial problems

(11) Continued professional development and contribution to national development through knowledge management.

### *Content*

The following areas are suggested as suitable contents for specialist level training. Modifications may be required to suit each country's context.

(1) Knowledge and skills for life-saving procedures

- Medical
- Obstetric
- Paediatric, including neonatal resuscitation
- Surgical
- Trauma

(2) Maintaining health

- Maternal and child health: Prevention, screening, health education, nutritional guidance and immunization
  - Ante-natal and post-natal check up
  - Well baby clinic
  - Family planning procedures

- Age-specific risk assessment including cancer risk
- Adolescent health
- Lifestyle guidance

(3) Principles of anaesthesia: local, regional and intravenous sedation

(4) Paediatrics

- Growth and development
- Infectious diseases
- Malnutrition
- Immunization
- Common paediatric illnesses

(5) General Medicine

- Initial management of all symptoms / health problems
- Recognition, assessment, management, follow-up of all common medical conditions in the community
- Prevention and health promotion
- Geriatric problems in the community
- Palliative care of terminally ill patients
- Poisoning
- Chronic disease conditions; hypertension, diabetes, asthma, ischaemic heart disease, obesity, epilepsy, osteoarthritis

(6) Diseases of public health importance. e.g.,

- Tuberculosis
- Leprosy
- HIV/AIDS
- STD
- Malaria

(7) Reproductive and sexual health problems including HIV / STD

(8) Common dermatological problems and investigations

(9) Mental health problems in a community setting

- Common psychological problems pertaining to life-cycle
- Behavioural problems
- Substance abuse
- Domestic violence
- Psychoneurosis
- Anxiety and depression
- Dementia
- Identification of at-risk patients by age, sex and environment

(10) Orthopaedics

- Reduction of simple fractures and dislocations
- Trauma management
- Fundamentals of physiotherapy

(11) Common ophthalmological problems, both curable and incurable

(12) Common problems in otolaryngorhinology

(13) Oral health: management of dental emergencies and preventive measures

(14) Occupational health

(15) Radiodiagnosis: interpretation of x-rays, preparation for radiological and imaging procedures, understanding interpretation and limitations of other imaging technologies

(16) Hospital and practice management

- Management science / organization
- Management of clinics
- Resource management

- Financial management
- Accounting and auditing
- Health economics and health insurance schemes

(17) Basic epidemiology and clinical epidemiology

(18) Biostatistics

(19) Information technology - information retrieval and handling, literature searches, use of interactive CDs and computer learning packages etc

(20) Behavioural and social sciences related to family medicine

(21) Medical education – Undergraduate and postgraduate teaching; education of allied-health staff, community

(22) Research methodology – use of quantitative and qualitative research methods, use of statistical packages, writing scientific papers

(23) Critical appraisal of literature and evidence-based medicine

(24) Communication skills with patients, peers, through media and publications

(25) Legal and ethical considerations in family practice

### *Procedural skills*

It is recommended that specialist level trainees should acquire the following procedural skills. Modifications may be required to suit each country's context.

(1) *Anaesthesiology*: Endotracheal intubation; intravenous access (peripheral and central lines, venesection, intravenous infusion); anaesthesia (local, regional, intravenous sedation)

(2) *Medicine*: Cardio-pulmonary resuscitation (CPR) and advanced cardiac, trauma, and obstetric life supports (ACLS, ATLS, AOLS), lumbar puncture, pleural aspiration, peritoneal aspiration, drainage of tension pneumothorax; nasogastric intubation and lavage;

intravenous, intramuscular, subcutaneous, intradermal and intralesional injections; intra-articular injection and aspiration; take an ECG

(3) *Obstetrics & Gynaecology*: Conduction of normal delivery, making and suturing of episiotomy, management of breech delivery and retained placenta; repair of perineal laceration; vacuum extraction, forceps extraction; speculum examination, cervical smear, IUCD insertion

(4) *Ophthalmology*: Funduscopy, removal of foreign bodies

(5) *Orthopaedics*: Splinting of fractures, reduction of simple fractures and dislocation; application of casts

(6) *Otolaryngorhinology*: Removal of foreign bodies from nose, syringing of ear, nasal packing; use of otoscope

(7) *Paediatrics*: Resuscitation of the newborn; intraosseous infusions

(8) *Pathology*: Haemoglobin level, erythrocyte sedimentation rate, total and differential leukocyte count, blood picture, routine and microscopic examination of urine and stool; taking swabs from various orifices and wounds; Fine Needle Aspiration; performing Gram stain and Ziehl-Neelsen stain; microscopy of urethral and vaginal discharge; blood sugar with glucometer; use of uristix

(9) *Surgery*: Assessment and closure of traumatic wounds; burns; incision and drainage of abscess; in-growing toenails; excision and biopsy of superficial swellings; venesection; urethral catheterization; suprapubic cystostomy; circumcision in adults; intercostal tube drainage; tracheostomy; screening for breast cancer

### *Teaching Methods*

The following teaching-methods are suggested for training at this level

(1) Group discussions, case presentations, journal review, topic review

(2) Clinical rotations in various clinical disciplines in teaching hospitals

(3) Posting under supervision of family medicine trainer

(4) Rotations in peripheral hospitals

(5) Posting in University academic Family Medicine Department

(6) Work on a research project, leading to submission of a dissertation

(7) Monitoring through a log book/ portfolio

(8) Self directed learning - reading medical literature, attending CME activities

***Assessment***

(1) Assessment should be both formative and summative.

(2) Formative assessments may be conducted at the end of each clinical posting, and summative assessment at the end of the course.

(3) Approval of the dissertation would be a necessary prerequisite for appearing in the final examination.

(4) Final summative examination may take the form of theory papers, clinical examinations, examination of a log diary, approval of the dissertation, and an oral examination.

# 6. CONCLUSIONS AND RECOMMENDATIONS

## Planning for the future

Dr Palitha Abeykoon reminded participants that the features of any society such as age structure, family structure, education, health and medical care, attitude to professionals etc. are constantly changing. Hospital-based specialist care is capital-intensive, labour-intensive, heirarchical, and personnel skills are often prescribed from outside. This system of care does not easily adapt to the changing needs of society. There are problems with 'undercare' and 'overcare'. The changing needs of society with the services provided by hospital-based specialist care has to be articulated through primary care. Family care has an all-important role to play in minimizing instances of both undercare and overcare.

The linkage and relationship between basic medical graduates, general practitioners, specialist family physicians, and other specialists and superspecialists was discussed. The scope of the services, provided by family physicians, have to be defined by the needs of the society in which they work, and the training received. Family physicians generally work primarily in an ambulatory care setting, and even surgical procedures may be done on a day-care basis. Hospital-based care may be delivered by a family physician in circumstances where the need arises, as in the most peripheral, rural stations. The specialist level training programme must take this into consideration. Family physicians need to be brought into the referral system within a country's health system, rather than working in isolation. In the ideal situation, a family physician may be considered a 'front-line' specialist.

Recognition of family medicine as a specialty will require action by universities, medical councils, health ministries, as well as professional bodies. Departments of family medicine should be established for teaching undergraduates as well as postgraduates.

The following recommendations were made:

### *For Member Countries*

(1) Family medicine should be recognized as a separate specialty in medicine.

(2) Immediate steps should be taken to incorporate the recommended core curriculum in family medicine into the existing basic medical curriculum

(3) Departments of family medicine should be established whenever and wherever possible for undergraduate and postgraduate training.

(4) Provision should be made for training of teachers for family medicine.

(5) Appropriate structures and cadres should be developed for incorporating general practitioners and trained family physicians within the national health system.

### *For WHO*

(1) WHO should support strengthening of capacity in training institutions in Member Countries to establish family medicine as a specialty.

(2) WHO should support countries to build their capacity in teach training in family medicine.

(3) WHO should facilitate development of a regional network and accreditation of family medicine training programmes.

(4) Strengthening of the health care services in Member Countries including primary health care, by incorporating family medicine in the national health systems should be supported by WHO.

## Annex 1

## PROGRAMME

**9 June 2003**

| | |
|---|---|
| 0800 – 0830 hrs | Registration |
| 0830 – 0930 hrs | Inaugural Session:<br>• Welcome address by Dr P T Jayawickramarajah, Coordinator - Health Systems, WHO/SEARO, New Delhi<br>• Message from Dr. Uton Muchtar Rafei, Regional Director, SEARO - Dr. Lokky Wai, Actg. WHO Representative to Sri Lanka<br>• Genesis of the Family Medicine Programme in SEA Region – Dr. Palitha Abeykoon, Consultant, WHO Office, Sri Lanka<br>• Remarks by the Secretary of Health, Nutrition & Welfare - Dr. Reggie Perera<br>• Remarks by Director, Post-Graduate Institute of Medicine (PGIM), University of Colombo – Prof. (Mrs) Lalitha Mendis<br>• Address by the Vice Chancellor, University of Kelaniya – Prof K Tilakaratne<br>• Address by the Chief Guest – Hon'ble Minister of Health, Nutrition & Welfare – Mr P Dayaratna<br>• Vote of Thanks<br>• Group Photograph |
| 1000 – 1230 hrs | Presentations:<br>• Family Medicine in National Health Systems<br>Dr P T Jayawickramarajah, Coordinator, SHS/SEARO<br>• The Role of WONCA in the Development of Family Practice – Prof Shatendra Gupta<br>• The Role of WHO in Development of Family Medicine – Dr. M Khalilullah |

- The Role of Professional Associations in Family Medicine – Dr A Kesanna
- Current Status of Educational Programmes in Family Medicine in Different Countries – Prof Nandani de Silva

1330 – 1530 hrs Country Presentations:
(15 minutes each, followed by discussions)
Nature of Family Practice / General Practice in SEAR Countries and an Outline of Current Educational Programme for Training Family Physicians / GPs:

- Prof A K M Shariful Islam – Bangladesh
- Dr B K Jain – India
- Prof Amal Sjaaf – Indonesia

1600 – 1730 hrs Country Presentations (continued)

- Prof Myo Myint – Myanmar
- Dr Manohar Gupta and Prof Gopal Acharya – Nepal
- Dr Prof Leela Karunaratne – Sri Lanka
- Prof Chaloem Varavithya – Thailand

**10 June 2003**

0900 – 1030 hrs Group Work:
Competencies in Family Medicine for Undergraduates (followed by discussions)

1100 – 1230 hrs Group Work (continues)

1330 – 1530 hrs Development of Objectives, Contents, Duration of Training, Assessment for Undergraduates – Group Work

1600 – 1730 hrs Group work (continues)

**11 June 2003**

0900 – 1030 hrs Competencies Required at Post-Graduates: Diploma Level and Specialist Level – Group Work (followed by discussions)

1100 – 1230 hrs Group Work (continues)

| | |
|---|---|
| 1330 – 1530 hrs | Development of Objectives for Post Graduates – Diploma and Specialist Levels – Group Work |
| 1600 – 1730 hrs | Identification of Content Areas and Learning Experiences - Group work (continues) |

**12 June 2003**

| | |
|---|---|
| 0900 – 1030 hrs | Plenary Session on Objectives and Subject Content (Followed by discussions) |
| 1100 – 1230 hrs | Discussions (continues) |
| 1330 – 1730 hrs | Field Trip to Family Medicine Centre in Faculty of Medicine, University of Kelaniya, Ragama |

**13 June 2003**

| | |
|---|---|
| 0900 – 1030 hrs | Presentation of Draft Document with Core Curriculum Recommendations, followed by discussions |
| 1100 – 1230 hrs | Approval of the Draft Document with Core Curriculum recommendations |
| 1230 – 1300 hrs | Closing Session |

# Annex 2

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