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General Practice Reformative Agenda, 2024

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Abstract

Introduction: General Practice, a longstanding specialty in Nepal, requires reformation due to changing professional context and growing health needs of the country. This study aims to identify key areas supported by evidence for the reformation of GP in the country.

Method: A qualitative study based on grounded theory was designed to explore the area of general practice and emergency medicine physician's working in Nepal. Focused group discussions, key-person interviews, polls, and debates were conducted. In the first round, key issues were identified, and in the second round, potential solutions were explored. Data was collected from 15 January to 23 March 2024. There was a panel discussion during the conference of General Practice and Emergency Medicine Association of Nepal in March 2024.

Result: Ten important themes that are important to reform the General Practice and Emergency Medicine physcian's situation in Nepal were identified. Important themes include: leading primary health care service considering a one-door policy, defined roles in all three tiers of health care system, adequate job posts, career ladder in sub-specialty, incorporating primary and emergency healthcare in academic curriculum, developing consistent competency based academic curriculum, advocacy for research wing in the association, ensuring primary teacher position during post graduate trainings, inclusion of general practice and emergency medicine subject in undergraduate curriculum, continuous knowledge and skill enhancement, and standardize specialty name.

Conclusion: This study has identified key areas to reformation which included diverse range of academics, curriculum, professional roles, job security, and research.

Keywords: General Practice; Health Policies; Reformative Agenda

INTRODUCTION

As in other low-middle income nations, there is a significant General Practitioners (GPs) have the potential to improve essential health service of the nation. Despite this GPs are underrepresented prompting the need for a closer examination solutions.[1] Access to surgical care can be enhanced by GPs, incorporating GPs into obstetric services is seen as a means to enhance maternal healthcare in rural Nepal.[2–4] Besides, the primary health care model led by GPs is identified as an effective platform for addressing Non-Communicable Diseases.[5] Moreover, including General Practice in the undergraduate curriculum could enrich the education of all medical undergraduates.[6,7]

There is a growing interest to enhance capabilities and the need for policy reforms to strengthen the role of GPs as first contact physicians in the healthcare system.[8-11] Medical Doctorate in General Practice (MDGP) was started in 1982.[12] With the changing landscape of healthcare over the past 42 years, it is the time to contemplate restructuring General Practice to better align with the current healthcare demands.

This study aims to provide a comprehensive understanding of the issues within General Practice in Nepal and proposes solutions to better support GPs, enhance their capabilities, and contribute to a more effective and accessible healthcare system in the country.

METHOD

This was a qualitative study started on November 2023 based on the theme of General Practice and Emergency Medicine International Conference, March 2024, Kathmandu, Nepal. The theme of the conference was "General Practice Reformative Agenda, 2024". This conference was organized by General Practice and Emergency Medicine Association of Nepal (GPEMAN). Data collection was started from February 2024 after ethical approval from Nepal Health Research Council (Approval Ref. no: 1297).

In Nepal, GPs have wide scope of practice from primary care to surgical , obstetric and emergency care. Emergency medicine is largly practiced by GPs in Nepal therefore the association is referred to as GPEMAN. The GPs referred to this study referres to the general practitioner with the range of practice in Nepal and is also referred to as general practice and emergency medicine (GPEM) physicians. Participants of this study are GPs of wide range of generations, working in government and private services, academicians and clinicians, and from residents to policy makers. The modality of research demanded inclusion of few selected participants with special expertise and experience to collect information in some of the tools. In most of the other tools, there was voluntary recruitment of participants. Therefore, a total number of participants or sample size was not applicable for this research. However, data saturation was considered as an essential end point.

The study design was based on grounded theory where data was collected through focused group discussion, key person interview, think tank group discussion, debate, workshop and panel discussion. The collected verbatin were transcribed and translated. Furthermore, open, axial and selective was done. Inductive analysis was done to build up theories. These theories were discussed in second round, form which deductive analysis was done to formulate themes. The phase one consisted of identifying the issues in general practice and phase two consisted of finding out the possible solution.

Focused Group Discussion (FGD) was selected based on the expertise and experience in the related focused group. Four groups were identified which included policy and strategies; primary care; medical education and research; and emergency care. Key Person Interview (KPI) was based on the issue that had been raised requiring expert opinion. In both cases, participants were selected by the General Practice Reformative Agenda 2024 committee based on the participants' expertise and experience and this selection was validated by the executive committee of GPEMAN. Participation in Think Tank discussions and Debate was voluntary. Thre were two think tank group, the first group consisted of participants affiliated to government health organizations recruited via the public service commission and the second group consisted of GPs outside the public service commission. Debate sessions were conducted in closed social media group with participation of significant number of GPs. Except for the panel discussion, all the participants were GPs. In panel discussion there were dignified panelists across diverse fields of health system in Nepal.

As GPs are spread all over the nation including remote places, virtual platforms like video conferencing, social media applications, and emails were used for communication. However, GPRA workshop and panel discussion were conducted in physical presence of GPs and delegates attending the GPEM International Conference in Kathmandu. For each discussion, there were moderator/s to facilitate the session and we had leading and probing questions in hand. Details of the study framework was already published in JGPEMN.[13]

Questionnaires that were developed were validated by group discussion and pilot testing. The validity of the transcription was obtained by PEER review of the content. An informed consent form was sent to participants via electronic medium. The verbatim was secured in a password-protected computer. Anonymity of the participant was maintained during the storage of data.

As the saturation point was not possible, in all ideas

due to the diversity of the population and the limitation of expertise, there is a possibility of confirmation bias. The team tried to minimize this bias by deductive and inductive analysis and confirming it in the larger group. No assumptions about the findings were made before or during the research from researchers.

RESULT

There were four focused groups in which the Policy and Strategy group had seven participants, Primary Care group had eight participants, Medical education and research group had seven participants and Emergency Care group had seven participants. The participants in FGD were senior administrative officers of the Ministry of Health and Population, Nepal (retired and currently working), professors and associate professors of medical universities, general practitioners working in the private and public health care system of Nepal.

Two key person interviews were conducted with resource persons for additional information, one of them was professor in medical university and the other was government official experienced in health policy. Two think tank group discussions were conducted in a closed group using social media platforms. The first group was open to all and the participation was voluntary. There were 36 participants out of which there were 9 active participants. The second group was with general practitioners working through a public service commission. There were 27 participants in this group out of which 7 were active participants. The panel discussion was conducted in the conference. There were five panelists consisting of: Ex. Minister of health and population and honorable Member of Parliament, Vice chairman of Medical Education Commission, Secretary of Ministry of Health and Population, Chairman of Nepal Medical Council, General Practitioner from UK currently practicing in Nepal. We had four focused group discussions, two key person interviews, and two think tank discussion groups. There were two rounds of discussion for each group. In the first round, we discussed the issues and in the second round we focused on the solutions for the issues identified in the first round. We had an open debate session in the GP&EM Viber group.

Following inductive and deductive analysis, ten themes were identified from the theories that were generated. These are as follows:

1. **Advocacy to amend the existing act to include Primary Health Care service which includes GPEM led health care system considering one door policy and incorporating a health insurance system.**

A key theme emerged around the need for health care services to be specifically tailored to Nepal's unique conditions, as highlighted by one participant: "*But what is needed is that our product is suitable for the soil of Nepal, isn't it the GP of Nepal?*" This emphasized the necessity for primary health care services that are adaptable to local needs. Participants strongly supported the leadership role of GPs in primary healthcare, with one stating, "So, it's time for the GP to lead." The challenges of delivering primary health care in remote areas were also emphasized: *"We now say that we provide primary care, but the remoteness is our reality."* This is a representative statement of collective voice on the need for policy amendments to effectively address the unique difficulties faced in these regions.

The importance of a personalized approach in primary healthcare was noted, indicating that "*In the concept of primary health care, personal central approaches, if it can be done by GP, the services of the highest level will reach every person.*" Additionally, the study identified several critical issues within Nepal's healthcare system. One participant pointed out the inadequacies in the healthcare infrastructure: "*There is no effective health care system to support BHS (Basic Health Service), EHS (Emergency Health Service) and insurance systems. The role of GPs in primary care and involvement in health insurance is not defined. To promote quality and sustainable health care in Nepal, GPs can be the gatekeepers for insurance*." This statement highlights the lack of an effective system to support BHS, EHS, and the health insurance system, highlighting the need for substantial reforms. The undefined role of GPs creates gaps in service delivery and coordination, as indicated by participants. Establishing GPs as gatekeepers for health insurance was suggested to enhance service efficiency and sustainability. One participant emphasized, "*Since 2014, one of our areas of quality is minimum service standards.*"; this highlights ongoing efforts to maintain quality through minimum service standards but also points to the need for further development and integration of these standards within the healthcare system.

2. **Advocacy for the roles of GPs in all three tiers of the healthcare system, ensuring job vacancies (revising O&M survey) and job satisfaction securing the adequate number of sufficiently trained GPEMs.**

The discussion was based around the concept that the health service based on a good healthcare system is better than a health care system tailored to health care service. Therefore, a system of GPs representing service delivery in all three tiers of government (Central, Provincial, and Local) is the core to a sustainable health care system in Nepal. This includes one door policy and engagement with health insurance.

Participants also emphasized the importance of including the Department of General Practice and Emergency Medicine in the upcoming Organizational and Management (O&M) survey: "*On coming O and M survey, we should include the*

department of general practice and emergency medicine." This inclusion would ensure that the contributions and needs of GPs are recognized in health system planning.

The study identified significant challenges for GPs, such as the lack of job positions, unfilled vacancies, and limited involvement in decision-making processes. One participant noted, "*There are very minimal job positions and unfilled vacant positions in government settings due to unrecognized work of GPs, poor policy for job vacancies, and poor demand of GPs in decision-making tier government bodies. This issue can be addressed by increasing job vacancies, advocating GPs roles in primary care, revising O&M survey, and coordinating with concerned authorities.*" Additionally, it was emphasized that the General Practice and Emergency Medicine (GPEM) departments should focus on advocating for their specific staffing needs rather than the broader vacancy issues within the entire healthcare system: "*General Practice and Emergency Medicine needs to specify and advocate their required vacancies and not the overall vacancies of the healthcare system*."

In remote settings, GPs often lead hospitals with responsibilities extending beyond primary care, including basic surgery and medical care, yet they struggle with lower salaries and limited professional opportunities. One participant highlighted this issue: "*GPs in remote settings lead overall hospitals with basic surgery and medical care; they are struggling with less salary and lack of professional opportunities. Motivation with added salary, key facilities, and giving focused professional development opportunities can be great options for GPs.*" Finally, in areas lacking super specialty or specialty services, GPs were identified as the first point of contact for managing the health insurance system. As one respondent explained, "*In places where there is no super specialty or specialty, GP will be the first person to take care of the health insurance system, such as a district hospital where there are 25 to 50 bed hospitals where there are not many specialty services, then the system of showing the GP as the focal person of health insurance or the first contact GP would be correct.*" This further emphasizes their critical role in the healthcare system.

Leadership roles for GPs at the provincial level were also discussed. One participant stated, "*Specifically in the case of the province, if we can give a place in the health ministry of the province and the health directorate of the province which also has a curative section, if we can give the lead to the GP, we can refine his leadership ability a little.*" This suggests that placing GPs in leadership positions within provincial health ministries and directorates can enhance their leadership skills and impact. Additionally, another participant emphasized, "*Apart from that, GPs should be placed in higher posts to increase their leadership capacity, which is suitable for GPs at policy making levels*," indicating the need for GPs to hold higher, policy-making positions to fully leverage their leadership potential.

3. Advocacy for career ladder to open up possibility for sub-specialty; national and international recognition; pathway in public and private health service.

The discussion focused around highlighting the need for structured career advancement, professional recognition, and supportive frameworks. Advocacy efforts were also highlighted as crucial for diversifying career pathways. As one respondent mentioned, "*Advocacy with Medical Education Commission, Ministry of Health and Population can facilitate the different career ladder options like Doctor of Medicine (DM), Magister Chirurgiae (MCh), Fellowship in critical care, palliative care, oncology, rural surgery, geriatric etc. and direct 11th level government position which can increase the horizon of GPs to go further for sustainable health care.*" This indicates the potential for GPs to pursue specialized training and higher-level government positions, thereby enhancing their career prospects and contributing to sustainable healthcare.

Collaboration was further emphasized as essential for career development. One participant noted, "*Need to collaborate with various national and international partners of public and private health service to identify the career pathways for GPs*." This statement highlights the importance of forming partnerships with national and international health service providers to establish and enhance career pathways for GPs, thereby broadening their professional opportunities.

Recognition of specific surgical and diagnostic roles, such as Ultrasound, was another significant theme. As one respondent collectively voiced, "*Our surgical and diagnostic roles like Ultrasound are not recognized in the country for which GPEMAN should work to collaborate with Medical Education Commission, Nepal Medical Council, Mnistry of Health and Population and radiologist association of Nepal to facilitate the process of recognition.*" This calls for collaborative efforts to advocate for the recognition of these roles, ensuring that GPs receive the professional acknowledgment they deserve.

4. Advocacy to incorporate Primary Health Care and Emergency Health Care to ensure that the foundation of GPEM education is based on BHS, EHS, and evidence-based care. This should be supported by essential skill programs and reformation in the curriculum.

The qualitative study revealed crucial insights into the multifaceted role of General Practitioners (GPs) in Nepal's healthcare system, emphasizing the need for a comprehensive approach to primary health care and the alignment of educational curricula with this scope. It was discussed that implementing a primary health care module is a huge undertaking requiring a large number

of human resources including GPs. Therefore, the feasible module to start with is GPs led BHS and EHS service. One participant noted, "*Primary health care means services such as preventive, promotive, diagnostic, curative, and rehabilitative.*" It advocates for integrating BHS and EHS into the curriculum of GPEM education. This integration ensures that future healthcare providers are equipped with essential skills grounded in evidence-based care, aligning with global health goals such as the World Health Organization's (WHO) Sustainable Development Goals (SDGs) that prioritize strengthening primary care services worldwide.

Another participant highlighted the perception gap concerning the role of GPs in remote areas, stating, "*Now WHO always says that the goal of this SDG goal is primary care, but what we still think is that GP means healthcare worker trained to work in rural areas?*" This statement reflects a discrepancy between WHO's emphasis on primary care within the SDGs and the local perception that GPs are mainly associated with remote areas. It questions what it means for GPs to be operational in these settings, suggesting a need to clarify and define their roles and capabilities in providing operative healthcare services in remote and urban areas.

The study also emphasized the importance of leveraging data and statistics to advocate for the expanded role of GPs in both remote and broader healthcare contexts. By publishing relevant data, advocacy efforts can demonstrate the capabilities of GPs across various policy levels, thereby enhancing their leadership in healthcare. This aligns with the suggestion that GPs should be recognized for their capacity to provide operative care in remote areas, thus supporting their professional recognition and leadership enhancement.

5. **Advocacy to ensure the consistent competency-based academic curricular framework of MD in GPEM that includes leadership, management skills, ethics, acts, regulations, and cross-cutting health care issues, across all universities.**

The curricular framework needs to be uniform, putting into account that the method can be diverse so that innovations are not restricted. One of the participants stated that, "*The curriculum needs to be uniform and there should be a common certifying exam.*" This underscores the necessity for a standardized curriculum across all universities offering the MD in GPEM, ensuring all graduates meet uniform competency standards through a common certifying exam. Such uniformity is crucial for maintaining consistency in education quality and the competencies of healthcare providers.

Further emphasizing curriculum development, another participant noted, "*There is a need for a competency-based curriculum and a separate body to monitor and check requirements and competencies gained.*" These advocates for a competency-based approach where the focus is on the essential skills and knowledge students must acquire. The call for an independent body to monitor and verify these competencies highlights the need for stringent oversight to ensure educational programs effectively prepare students for their roles as GPs.

The inclusion of leadership and management skills was also highlighted as a crucial component, with one participant stating, "*Leadership and management should be addressed in the curriculum.*" This reflects the recognition that GPs often need to assume leadership roles and manage healthcare teams, particularly in settings where they are the primary healthcare providers.

Moreover, the need for a comprehensive curriculum was emphasized by another participant who stated, "*The curriculum should be robust including ethics, communication, regulations, geriatric, palliative, communicable and non-communicable diseases etc.*" Such an inclusive approach ensures that GPs are well-prepared to address the diverse healthcare needs of their patients.

The study also revealed the challenges faced by GPs and residents in maintaining updated knowledge and skills post-graduation. One participant pointed out, "*GPs and residents are struggling with updated knowledge and training skills after post-graduation. GPEM training and academic pathway needs to be defined. The foundation of GPEM education should be based on BHS and EHS and evidence-based care. GPEMAN need to collaborate with other fraternities to provide skills and training and get accredited certificates. Examples- Comprehensive abortion care, Manual aspiration, Non scalpel vasectomy, Minilap, USG, Echocardiogram.*" This highlights the need for clear training pathways and academic frameworks, with a focus on BHS, EHS, and evidence-based care, as well as collaboration for skill enhancement and accreditation.

6. **Advocacy for the research wing in GPEMAN to facilitate research training, and fundraising for high-quality evidence-generating research that will have a long-term impact on policy, knowledge, and practice for the country.**

The study highlighted the requirement of research and its capacity building. One participant noted, "*Research should be an integral part for the progress of GPs in Nepal.*" This statement emphasizes several key benefits of incorporating research into GP practice which are: evidence based practice, professional development, policy advocacy and health care improvement, addressing local health issues, collaboration and knowledge sharing. One participant further highlighted, "*More research from GPs to as 'If we can publish such data and statistics, surely it will help us to advocate on other*

policy levels that GPs are fit for everything.' And enhance our leadership." This emphasizes the importance of GPs conducting and publishing research to gather data that advocates for their capabilities across various policy levels. By demonstrating their competence through research, GPs can enhance their leadership roles within the healthcare system.

7. Advocacy to ensure academic activities for general practitioners in post-graduate programs in such a way that it is mostly led by general practitioners as a primary teacher.

This study revealed a strong advocacy for increased emphasis on general practice during residency training. As one participant stated, "Increase focus in General practice (60-70%) during residency than other sub-specialties." This suggestion aims to allocate 60-70% of the residency curriculum to general practice, ensuring that future general practitioners (GPs) receive comprehensive training in their core field. By focusing predominantly on general practice, residents can build a strong foundation, equipping them to handle a wide range of medical issues and become effective primary care providers.

Further, the study highlighted the necessity of having experienced GPs lead the majority of the training programs, as indicated by the statement, "*We need to build up the capacity and curriculum so that most of the training is with general practitioners.*" This approach ensures that education and training are grounded in practical, real-world experience and expertise. Experienced GPs as primary educators foster a more relevant and practical learning environment, enhancing the quality of training. Moreover, it promotes mentorship and role modeling, providing residents with valuable insights and guidance from seasoned practitioners.

8. Advocacy for compulsory inclusion of GPEM as a subject along with rotations in the GPEM department in the undergraduate medical education.

The study also underscored the importance of including General Practice and Emergency Medicine (GPEM) as a core subject in undergraduate medical education, with rotations in the GPEM department. One participant emphasized, "*Primary care is the foundation of the health care system therefore it should be taught from the beginning*." This statement highlights the need to introduce primary care principles and practices early in medical education, ensuring that students appreciate the critical role of primary care from the outset. Early exposure to primary care fosters a comprehensive understanding of holistic patient care, preparing future doctors to manage common health conditions effectively.

Moreover, the study advocated for the establishment of dedicated GPEM departments in medical colleges and the inclusion of rotations in these departments, as reflected in the statement, "*There should be a GPEM department in medical colleges and rotation of medical students in the department.*" Rotations in the GPEM department provide medical students with practical exposure to the responsibilities and challenges of general practitioners and emergency medicine specialists. This hands-on experience is crucial for developing clinical skills, critical thinking, and patient management abilities, essential for effective primary care. It also underscores the importance of GPEM in the broader healthcare system, encouraging more students to consider careers in this field.

9. GPEMAN will emphasize the need for continuous skill enhancement to ensure the best practice and patient safety recognizing the continuous change of disease profile and patient needs in the population.

The qualitative study emphasized the importance of continuous professional development for General Practitioners (GPs) in adapting to the evolving healthcare landscape and ensuring best practices and patient safety. One participant stated, "*GPEMAN should organize regular training and Continung Medical Education (CME) through physical or virtual platforms*," highlighting the necessity for regular skill enhancement.

Continuous skill enhancement is essential for adapting to changing disease profiles, as the healthcare landscape is constantly evolving with new diseases emerging and existing ones changing in presentation and treatment. Regular training programs, workshops, and updates on new treatment protocols ensure that GPs remain informed about the latest medical advancements. This proactive approach helps GPs effectively manage these changes and maintain high standards of patient care.

Moreover, ensuring best practice and patient safety is a fundamental aspect of high-quality healthcare. Continuous professional development through regular training and Continuing CME sessions ensures that GPs apply the most current evidence-based practices in their clinical work. This focus on skill enhancement improves diagnostic accuracy, treatment effectiveness, and overall patient outcomes, thereby ensuring higher standards of patient safety.

Regular training sessions are crucial for updating GPs on the latest medical techniques, technologies, and treatment protocols. These sessions provide opportunities for hands-on practice and skill refinement, which are essential for mastering new skills and procedures. The CMEs offer ongoing educational opportunities that cover a wide range of topics relevant to everyday practice. The GPEMAN can organize CMEs that include lectures, workshops, case studies, and discussions led by experts, ensuring a

comprehensive approach to continuous learning.

Offering training and CMEs through both physical and virtual platforms ensures accessibility and convenience for all GPs, regardless of their location. Physical platforms provide hands-on experience and direct interaction with trainers, while virtual platforms offer flexibility and the ability to reach a wider audience. Virtual training, such as webinars, online courses, and virtual workshops, allow GPs to participate from remote locations or during their own time, maximizing participation and learning opportunities.

10. Standardize the specialty name reflecting the roles and responsibilities of GPEM in Nepal while considering international norms.

The qualitative study underscored the need to standardize the specialty name of General Practice and Emergency Medicine (GPEM) in Nepal to accurately reflect the roles and responsibilities of practitioners in this field, while aligning with international norms. Participants emphasized that a clear, standardized name would not only enhance the recognition and understanding of the specialty but also ensure consistency in training and practice standards. Such standardization would facilitate better alignment with global medical practices, enabling GPEM professionals in Nepal to meet international benchmarks and improve cross-border professional recognition. This approach aims to bolster the credibility and professional identity of GPEM practitioners, ultimately enhancing the quality healthcare delivery in Nepal.

DISCUSSION

This qualitative study identified ten important themes that might help to transform GPEM in Nepal and fulfil the current need of the country. Medical field is changing day by day, so does the GPEM fraternity. Findings from this study are supposed to update GPEM in Nepal and rise up to international standards.

1. Advocacy to amend the existing act to include Primary Health Care service which includes GPEM led health care system considering one door policy and incorporating a health insurance system.

According to the Astana declaration 2018, strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.[14] UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. As a foundation for and way to move towards UHC, WHO recommends reorienting health systems using a primary health care (PHC) approach. It enables universal, integrated access to health services as close as possible to people's everyday environments. It also helps deliver the full range of quality services and products that people need for health and well-being, thereby improving coverage and financial protection. Significant cost efficiencies can be achieved and most (90%) essential UHC interventions can be delivered through a PHC approach.[15]

For a well-functioning health care system, it should have a robust primary health care. When we talk about providing Basic health services, we first imagine primary health care. A well-functioning and effective health care system can be the NHS.[16] It has GP led Primary health care and every patient needs to first contact their family physician/ GP before fixing an appointment with the specialist doctor. The GPs system has been at the heart of the NHS for over 75 years of its existence, and the whole system is well developed and without interruption. After 75 years of evolution, GPs have transformed from health gatekeepers to health agents. The responsibilities of GPs are expanding from providing diseases treatment to integrating treatment, prevention and health promotion. The health agent role of the GP can be defined in this way: entrusted by the individual and the state, in addition to providing disease treatment and referral services to patients, the GP also takes the initiative to provide health-related public health services, such as disease prevention, health education, health management and health monitoring services etc., to healthy registered residents. Previously, as health gatekeepers, GPs provided disease treatment and referral services to patients, and now, as health agents, they provide health management services to residents. As health agents, the GPs combine public health services with clinical services. The advantages of this are that, on the one hand, since the service is provided proactively, the decentralization of public health services to the GPs improves the accessibility of public health services to the residents, thus increasing the utilization of public health services; on the other hand, the overall health of society is improved when disease treatment service provided by health gatekeepers is gradually replaced by health management by health agents.[17]

The development of health insurance in Nepal has been gradual, with initiatives dating back to 1976. In 2017, the Health Insurance Act was enacted by the government then Health Insurance Board (HIB) came into existence. The National Health Insurance Program (NHIP) under the HIB, provided financial risk protection through health insurance to the Nepalese population. By the end of 2022 it was implemented in all 77 districts. The design of the health insurance scheme follows a typical approach used by low-

and middle- income countries transitioning away from user fees. The NHIP's benefit package covers emergency services, outpatient consultations, inpatient services, selected medicines, and diagnostic services.

Particularly the gatekeeping characteristic of the health insurance scheme has primary health care centers as its key feature.[18] However, no definite role of primary care physicians has been defined. Section 13, Subsection 1 of Health Insurance Act 2017 mentions formation of the board members, GPs should be a part of the board and well define the role of primary care physicians including guidelines for referrals hence clarifying our roles as gatekeepers of the health system.[19]

In Nepal any person can consult any doctor at present. There is merely anyone who can guide the patient about the appropriate specialist they need to visit. Sometimes for minor issues that can be solved by GPs, patients visit specialists which ultimately increases waiting time of patients and decreases quality of care. If there would have been any health persons who can screen these patients, take care of their health issues, and refer the complicated cases to appropriate specialist; it would decrease the health care cost, minimize waiting time and increase the quality of care. GP led primary health care can reduce hospitalizations.[20]

There is a need to empanel more health facilities in NHIP, as most local levels currently do not have NHIP-listed health facilities. An assessment to conduct the feasibility of health facilities for their potential empanelment could support this objective. Strengthening NHIP is essential for Nepal's goal of achieving universal health care.[18]

The most appropriate health manpower with knowledge of every field is GPs. We know that patients benefit, at all ages, from proactive approaches by general practitioners and their teams through listening, asking questions, providing information, and intervening to protect health and prevent disease as well as providing diagnosis, treatment, and continuous care.[21] So, the government needs to think about implementing a one door system in health care where patients first need to visit a GP then the appointed GP will handle the health condition of that person. If that person needs to visit a specialist, then the GP will guide through the process and will follow the patient after s/he gets back from the specialist. Though the government tried to implement this by making compulsory visits to primary centers by insurance clients before visiting any secondary or tertiary care, still there are lapses. First, there are no GPs in all primary centers and if they are there too, they are outnumbered to see all patients. Patients rarely follow back to the GP after getting consultation from a specialist.

It is now recognized that a health system, which is not primary care-led is weak and expensive and primary care without fully trained family physicians is of poor quality.[21] Government should implement a one door system not only in Primary care centers but also in secondary and tertiary centers. For that we need to acknowledge the inadequacy of the number of GPs in our country and increase production of GPs and adopt policies favorable to implement GP led PHC and one door policy of health care system. From acting as gatekeepers we should gradually lead a pathway to become health agents.

2. Advocacy for the roles of GPs in all three tiers of the healthcare system, ensuring job vacancies (revising O&M survey) and job satisfaction securing the adequate number of sufficiently trained GPEMs.

The health system worldwide run heavily on health professionals.[22] However, there is shortage of health workers globally, particularly in low and middle income countries like Nepal.[23,24] Despite adjustments for sociodemographic factors, the supply of GPs has been associated with improved health outcomes, such as reduced mortality rates, better self-reported health and increased life expectancy.[23]

Countries with strong primary care systems tend to incur lower health care costs compared to those with weaker primary care systems. A poor orientation towards primary care is linked to worse health outcomes whereas an increase in primary care physicians significantly lowers mortality rates, and there is significant negative relationship between the family physicians to population ratio and hospitalization rates. Primary care has a noteworthy impact on health equity.[25]

Public health service act 2075 of Nepal states that the government of Nepal shall provide specialized services as necessary on the basis of nature of service, geographical condition and the burden of disease in the region and the necessary health human resources are to be provided by the government.[26] Similarly, the Public health regulations further states General Practice specialized service and general practitioner specialized human resource which places the General Practitioner in specialized government health facilities rather than peripheral health facilities.[27] The National health policy 2019, also has a provision that states that an MDGP shall be appointed at primary hospitals at all level.[28]

According to the national Human Resources for health (HRH) Strategy 2021-2030 (2021), the number of General practitioner in 2020 was 187 which is projected to increase to 1050 by 2030 and in order to support this increase the strategy aims to establish medical institutions as per need as also support continuous professional development among the health resources. Furthermore, the survey conducted among the zonal level hospitals and above

health institutions in 2015 depict only 48% of the specialist doctors and 52% of the general practitioners positions have been fulfilled (Ministry of Health and Population, 2021).[29]

The constitution of Nepal, Local government operation act, 2074, Public health act, 2075, National medical education act, 2075, Public health regulation 2077, National health policy, 2076 etc are the major policy, regulations and acts supporting the human resource for health. [26,28,30–32]

There are few barriers to this. The government's data and documentation process are fragile. As a result, there are now no open positions for the job, which are unfilled due to contracts, temporary workers, employees on long-term leave and employees on educational leave. Retention and decentralization of the available health care workforce are issues, as are difficulties in maintaining pay, benefits, and infrastructure and attitude development. This creates problems on human resource management and lack of funding resources at provincial and local level and adds to the misery. Furthermore, the health sector's overall budget is not sufficiently allocated, which makes it difficult to recruit new employees and raise salaries.[29]

The lack of coordination between organizations in charge of using the healthcare workforce that is produced and academies involved in its production and the disparity between the quantity and quality of the workforce produced in healthcare act as the barrier to the job recruitment and satisfaction.[29]

Flexible hiring and training practices for workforce development have been made possible by federalization. Nonetheless, federalization has sparked serious worries about widening gaps and misaligned goals in terms of funding and workforce development.[33] Thus, the restructuring of the health system as per the norms of federalism is mandatory. It is imperative to have the development and uplift of the specialists and general practitioners by creating the newer job vacancies in the government system at all the three tiers of government. Furthermore, the allocation of the budget in the health sector should be robust and as per the guidance provided by the WHO. In addition, legal reform should be initiated for the ways to human resource management immediately.[29]

Since the GPs have the most influential role in the health care delivery, addressing the shortage of general practitioners is crucial. The scarcity of the general practitioners in the government health care system requires long term planning and acknowledgement that the improvement will take many years. Moreover, top down targets are not likely to be effective in workforce supply-demand deficit, so consideration of the geographic and sector variation in supply and demand is important.[34] Also, Insufficient funds result in irrational choices and false estimates, while funding without preparation runs the danger of creating inefficiencies as well as waste. Therefore, smart (targeted) funding is necessary to generate the best benefits.[34] The optimum utilization of resources by optimizing the use of different acts and policies will help to plot the roadmap for O&M survey and recruitments.

3. Advocacy for career ladder to open up possibility for sub-specialty; national and international recognition; pathway in public and private health services.

The World Association of Family Doctors (WONCA), have underscored the paramount importance of family medicine in revitalizing primary care services.[35] Career in general practice in the globe is challenging. With changing health demands of the country, Nepal is not able to distribute general practitioners (GPs) and other health care workers effectively with fewer career options. However, GP is a boundless career option with respectful and attractive opportunities in UK[36] and many parts of Europe.[37]

Doctorate of Medicine (DM) in Emergency medicine[38], DM in critical care[38] already exists in Nepal as career options for GPs and fellowships for palliative care[39] and diabetes[40] are also pathways for professional opportunities but postgraduate study in oncology, mountain medicine and rural surgery needs explorations as sub-specialties for GPs. Another career pathway for GPs in Nepal in government setting includes medical generalist at 9th level of Public Service Care, as different positions such as medical director, hospital In-charge, and clinical coordinator in private health care settings and lecturer, assistant professor, associate professor and professors in medical colleges and universities.

Lack of GP led strong leadership, under-recognition of GP's work in health care in Nepal, Lack of identification of GP's role in health policy of Nepal, inadequately created GP's vacancy in public service, less effort in creating fellowship academic programs by universities and medical colleges, lack of international recognition collaboration, less PG seats for GPs and lack of motivation are the key factors associated with career growth and sub-specialty options for GPs.

A strong policy with a detailed GPEMAN led road map and approved guidance from collaboration with MEC, NMC and MOHP should be the driving step to offer multiple career options and sub-specialty for GPs.

4. Advocacy to incorporate Primary Health Care and Emergency Health Care to ensure that the foundation of GPEM education is based on BHS, EHS, and evidence-based care. This should be supported by essential skill programs and reformation in the curriculum.

Primary health care (PHC) has evolved throughout the past

century. Since the early part of the twentieth century, PHC has been identified as a core component of an effective health system. The Declaration of Alma Ata in 1978 put primary health care on the global agenda.[41] Declaration of Astana at global conference on primary health care in 2018 stated that "strengthening primary health care is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being." It further states that "PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals (SDG)."[14] The primary health care performance initiative (PHCPI) framework launched in 2015 offers a stronger emphasis on people- and community-centered care, supply and demand functions, and integrated service delivery through effective organization and management. By implementing PHCPI framework we have an opportunity and a responsibility to go beyond antiquated notions of levels of care, simplified packages of care, or overly broad but under-defined concepts of primary health care, to move toward comprehensive, coordinated care that puts people and their needs at the center.[41]

Emergency Medicine (EM) is a young specialty that has become well established and mature in a relatively small number of countries. In the last three decades, emergency medicine in Nepal has undergone tremendous growth. There is no structured or formalized listing of the practice models. Therefore, the scope of practice is variable. Crowding patient population, increase in hospital stay, and increasing demand for outpatient urgent care services have all contributed to overcrowding and extended stays in the emergency department. Thus, the role of the Nepalese emergency physician has evolved over the years to include acute, inpatient, as well as critical care medicine. As an evolving new specialty in Nepal, EM is undervalued in most centers and suffers from lack of recognition and support from other departments and hospital administration. Emergency physicians are not viewed as "specialists" by the general public.[38]

We should first determine the level of EM development in our country with the classification scheme based on specialty system, academic EM, patient care systems and management systems. Secondly, we should move towards improving each of these aspects.[42]
United States realized need of formal training in Family Practice during 1960s and 1970s.[43] Nepal started MD GP (MD in General Practice and Emergency Medicine) residency program in 1982. This program has been since providing emergency care physicians for the country.[38] During the start of the residency program, it was envisioned that residents after completing their training in General Practice would be capable not only of primary care but would also be able to tackle most of the emergency cases and surgical interventions because of the extreme lack of other specialties in the country. General Practitioners of Nepal slightly differ from the general practitioners of the other countries in that they have extra surgical skills for example: laparotomy, appendectomy, cesarean section, hernia surgeries etc.[10]

Hence in Nepal, the general practitioners providing both primary health care and emergency care suffer from a major non recognition. A survey done in a Continuous Medical Education (CME) program of General Practice and Emergency Medicine Association of Nepal (GPEMAN) showed that majority of participants pointed out that poor health policy and lack of recognition of General Practice for primary health care as first contact physicians by the government are the major challenges and barriers.[10]

A report of regional meeting in Bangladesh on PHC approach on emergencies recommends that the national health policy should include a policy on health emergency as part of health systems strengthening based on PHC.[44] However, the scope of PHC approach was only limited to emergency situations/disasters, in the report. Nonetheless, it pushes the point that PHC and emergency care could go hand in hand. PHC and emergency care, both being the first point of contact within the health system, if could be provided by the same health workers, would be beneficial. GP-led primary care will reduce the unnecessary crowding of patients in tertiary care centers.[10]

A pilot study done in 2021 for emergency unit assessment in 7 tertiary level hospitals of Kathmandu using the WHO Hospital Emergency Unit Assessment Tool (HEAT) has identified gaps in emergency care. The study recommendation includes ensuring universal staff training and competency with focus on certain procedures, considering cross- institutional collaboration in training programs, ensuring cross- sectional collaboration in sharing written protocols.[45] We further need crash courses like ACLS, PALS, ALTS, PHTLS, and AWLS for development of emergency care in Nepal.[38] Hence, highlighting the importance of reformation in the curriculum.

We should address the identified gaps in emergency care and consider the recommendations, beginning with competency building, cross institutional collaboration in training programs and cross sectional collaboration in sharing written protocols.

The constitution of Nepal has assured the right to free basic health and emergency health services. "Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services… And every citizen shall have equal access to affordable quality health services" (Nepal Constitution 35:1&3, 2015). Public Health Act of Nepal 2018, states, "Every healthcare organization is required to provide emergency health care."

National Health Policy 2019 emphasizes the need to make Emergency Health services available at all levels including Basic Health Centers and Primary Hospitals.[46]
Though Nepal's constitution guarantees state-free emergency care to its citizens, recent national disasters have exposed gaps in emergency care access and infrastructure in the country.[45]

The World Bank disease control priorities estimate that more than half the deaths and around 40% of the total burden of disease in low- and middle-income countries (LMICs) result from conditions that could be addressed with emergency care.[45]

The Nepal Ministry of Health and Population (MoHP), in collaboration with the World Health Organization (WHO), has undertaken a national system-level assessment using the WHO Emergency Care System Assessment (ECSA) tool.[45] They have been providing Basic Emergency Care and Emergency Care Toolkits trainings to the health workers in Emergency department for strengthening of the emergency Care system. Incorporating such training within the residency program would help to build competency. Our national health agendas focus both on PHC and Emergency health care. By aligning with these national agendas, we can advocate better to incorporate PHC and EHC, and hence strengthen the foundation of GPEM education. Moreover, involving more doctors in the national trainings aimed at strengthening PHC and emergency care would help us with both -building competency and developing uniformity.

5. Advocating for a consistent competency-based academic curricular framework for MD programs in General Practice and Emergency Medicine (GPEM), inclusive of leadership, management skills, ethics, acts, regulations, and cross-cutting healthcare issues, across all universities

Establishing a uniform framework ensures that MD programs in GPEM meet consistent standards of quality across different universities. This helps to uphold the reputation of the profession and ensures that graduates are adequately prepared for their roles in clinical practice. The World Health Organization's (WHO) "Guidelines on Medical Education" (2021) underscore the importance of holistic medical training that integrates leadership, ethics, and regulatory understanding into curricula.[47] A standardized curriculum ensures that all students, regardless of the university they attend, have access to the same foundational knowledge and skills. This promotes equity in education and helps to address disparities in healthcare delivery by producing competent practitioners in all regions. The Association for Medical Education in Europe (AMEE) has been at the forefront of promoting global standards for medical education. Their publication "Global Standards for Medical Education" outlines core competencies that encompass leadership, management skills, ethics, and regulatory knowledge, aligning with the proposed framework for MD in GPEM.[48] Additionally, the Liaison Committee on Medical Education (LCME) has set accreditation standards that emphasize the importance of comprehensive medical training, including ethical and regulatory components.[49] The Indian National Medical Council (NMC) mandates competency-based post-graduate training in ophthalmology, employing innovative teaching methods to produce skilled ophthalmologists equipped for contemporary practice.[50]

Including leadership, management skills, ethics, acts, regulations, and cross-cutting healthcare issues in the curriculum ensures that graduates are not only clinically competent but also well-rounded professionals capable of addressing the complexities of modern healthcare systems. This better prepares them for the challenges they will face in real-world practice. Healthcare systems are constantly evolving, with new regulations, technologies, and challenges emerging regularly. A curriculum that includes these elements ensures that MD programs remain relevant and adaptable to changes in the healthcare landscape, producing graduates who are prepared to navigate and contribute to ongoing advancements. Incorporating ethics and professionalism into the curriculum helps to instill values such as integrity, empathy, and respect for patients' rights. This is essential for fostering a culture of ethical practice and ensuring that graduates uphold the highest standards of professionalism throughout their career. Advocating for a consistent framework helps universities align their programs with accreditation requirements, facilitating accreditation processes and ensuring program quality. The Accreditation Council for Graduate Medical Education (ACGME) plays a pivotal role in accrediting medical education programs leading to the MD degree. Their "Program Requirements for Graduate Medical Education" highlight the core competencies expected of medical graduates, including professionalism, communication skills, and systems-based practice, which are integral to the proposed curricular framework.[51] Furthermore, the World Federation for Medical Education (WFME) has developed "Global Standards for Quality Improvement" in basic medical education, emphasizing the need for competency-based approaches. Patan Academy of Health Sciences is the only academic institution in Nepal to follow the competency based post-graduation program.[52]

To advocate for this cause effectively, stakeholders such as professional associations, academic institutions, policymakers, and healthcare organizations should collaborate to develop consensus on the essential components of the curriculum and advocate for their integration into MD programs in GPEM across all universities and not just one. This may involve conducting research, engaging in policy dialogue, sharing best practices, and

mobilizing support from relevant stakeholders to promote the adoption of standardized curricular frameworks.

Challenges in implementing competency-based medical education include cultural differences, resource constraints, and varying educational systems. Jayson discuss these barriers in their article, emphasizing the need for addressing systemic challenges to ensure effective implementation.[53] Similarly, Mews et al. highlight cultural considerations in global medical education frameworks, pointing out the complexities of aligning diverse educational contexts with competency-based approaches.[54]

The International Association of Medical Regulatory Authorities (IAMRA) provides "Guidelines for Competency-Based Medical Education Implementation," offering practical strategies for overcoming barriers and fostering collaboration among stakeholders.[55]

By leveraging these resources and collaborating with international stakeholders, advocates can drive the adoption of a consistent competency-based academic curricular framework for MD in GPEM, ensuring that future medical professionals are well-equipped to address global healthcare challenges effectively.

6. Advocacy for the research wing in GPEMAN to facilitate research training and fundraising for high-quality evidence-generating research that will have a long-term impact on policy, knowledge, and practice for the country.

One of the issues raised by many participants in this study is "Advocacy for the research wing in GPEMAN to facilitate research training and fundraising for high-quality evidence-generating research that will have a long-term impact on policy, knowledge, and practice for the country."

The international community has been active in promoting research within general practice and emergency medicine, recognizing its critical role in improving healthcare outcomes. For example, the National Institute for Health Research (NIHR) in the United Kingdom provides extensive funding and training programs aimed at generating high-quality evidence to inform clinical practices and health policies.[56] Similarly, the National Health and Medical Research Council (NHMRC) in Australia supports health research through funding, fellowships, grants, and fostering a robust research environment.[57] These examples highlight the significance of dedicated support and infrastructure for advancing medical research and can serve as models for Nepal to emulate in strengthening its research capabilities in general practice and emergency medicine.

In Nepal, there are several foundational policies and regulations that support health research, although they require further enhancement to be truly effective. As a resident of MD in General Practice and Emergency Medicine one has to write a thesis as a part of research to clear the residency program. The research committee of the University helps with research training and the Department of General Practice and Emergency Medicine helps the resident by assigning a guide and co-guide for the thesis. The Nepal Health Research Council (NHRC) has been a pivotal institution in promoting health research across the country, offering guidelines and ethical standards for conducting research.[58] The NHRC also provides small amounts of grants at times for research. The Nepal Medical Council (NMC) also mandates research as a component of medical education and professional development.[59] These regulations highlight a framework upon which more robust support mechanisms can be built but currently lack the necessary resources and incentives to fully realize their potential. Strengthening these policies with concrete support and clearer pathways for research funding and training is essential for nurturing a thriving research culture in Nepal.

Despite these existing policies, several barriers continue to impede the advancement of research in general practice and emergency medicine in Nepal. The primary challenges include insufficient funding, limited access to research training, and inadequate infrastructure to support extensive research activities. Additionally, there is often a significant disconnect between researchers and policymakers, which hampers the effective translation of research findings into actionable health policies. Overcoming these barriers requires a comprehensive strategy that addresses both resource limitations and systemic issues, ensuring that research can be conducted effectively and its results applied in practice and policy-making.

To initiate the development of a robust research wing within the General Practice and Emergency Medicine Association of Nepal, a multi-faceted approach is needed. Building a coalition of stakeholders, including government agencies, academic institutions, and international partners, is a critical first step. Establishing dedicated research training programs and securing funding through grants and partnerships with international research bodies will be crucial. Additionally, fostering a culture of collaboration between researchers and policymakers can ensure that research findings are effectively integrated into health policies and practices. Creating a supportive ecosystem for research not only enhances the capacity for evidence generation but also ensures that this evidence is utilized to improve healthcare outcomes in Nepal.

In conclusion, advocacy for the research wing in the General Practice and Emergency Medicine Association of Nepal is essential for facilitating high-quality evidence-generating research. Learning from international models, strengthening existing policies, and addressing current

barriers will be vital steps in this process. By building a strong coalition of stakeholders and securing the necessary resources, Nepal can create a sustainable and impactful research environment. This will ultimately lead to better-informed health policies and practices, improving the overall healthcare landscape in the country.

7. Advocacy to ensure academic activities for general practitioners in post-graduate programs in such a way that it is mostly led by general practitioners as a primary teacher.

Ensuring GP as primary teacher during PG training of GP was one of the key suggestions from participants. Most of the nation involves rotation in multiple specialties during the training of MD in General Practice and Emergency Medicine / Family medicine with varying duration in each department.

In India, the National Board of Examination has set a curriculum where trainees in MD Family Medicine will rotate in various departments of Medicine, surgery, gynecology, obstetrics, family medicine and emergency medicine for a designated period of time. To facilitate trainees, there will be one principal trainer or guide preferably from General Practice for each trainee. There will be a rotation supervisor from concerned speciality who is responsible for productive and positive experience during the posting.[60] In the UK, clinical supervisors on placements and the educational supervisor (GP trainer) are principal trainers. The role of clinical supervisors is daily supervision in clinical settings. They provide teaching, developmental conversations and regular feedback and are first-line contacts for any issues. GP trainers assume responsibility for monitoring trainees' clinical and educational progress.[61] At University of Pennsylvania Medicine, residents of Family Medicine are paired with faculty advisors (1:1) and senior residents. They are rotated in various departments like Family Medicine (FM) office, FM inpatient, FM Obstetrics, Internal Medicine, Pediatrics, CCU, OB/Reproductive Health, etc.[62]

As in other nations, in Nepal also, GP trainees are rotated in various departments (General Practice and Emergency Medicine, Internal Medicine, Surgery, Gynecology and Obstetrics, Radiology, Pediatrics, Anaesthesiology, Dermatology, Psychiatry and few other optional rotations). Duration of rotation is as per university. In most of the institutions, faculty at the concerned departments are primary trainers. GP faculty acts as coordinator between the department and trainees. There will be direct contact between GP faculty and trainees when trainees have rotation in General Practice and Emergency Medicine and during academic sessions which are mostly held once a week.

All academic institutes in Nepal do not have separate GP OPD. GP IPD is a rare one if we forget about the Emergency observation ward for a while. When GP trainees are rotated in other specialties, GPs are trained along with their residents which do not fulfill the goal of GP. If there will be presence of GP faculty for each department or selected faculties of concerned departments are oriented to the need of GP trainees then the issue may be solved to a certain extent.

Establishment of GP OPD and IPD is the basis for training GPs as GP faculty being primary trainers. There should be a GP faculty responsible for coordinating academic activities dedicated to each department. One or two faculties of concerned specialty departments should be oriented to the needs of GP trainees and make it responsible to supervise the GP trainees when they are posted in respective departments.

8. Advocacy for compulsory inclusion of GPEM as a subject along with rotations in the GPEM department in undergraduate medical education.

General practice(GP) refers to providing first contact, comprehensive, continuing and community based care that meets the health-related needs of people.[63] In the recent years, the evidences are getting stronger that a solid primary health care system is essential for better outcomes of health-related indicators including equity, use of resources compared to specialty-oriented care. This emphasizes the heightened role of GPs for a strong and sustainable health care system.[64] Hence, a substantial part of graduating doctors needs to be trained to work in a GP setting and studies have shown that undergraduate education positively influences the career choice in future.[64,65] In a descriptive study done across Europe which included medical schools, 13.5% of the universities did not have General Practice or Family medicine (FM) included in their undergraduate curriculum.[64,65] Similarly, 50 medical schools, mostly in Southern and Eastern Europe, reported either a lack of or only very brief FM programs and there is a scarcity of published literature about the development and implementation the FM program in the undergraduate curriculum in the Eastern Mediterranean Region (EMR).[66]

Lack of agreement on identity of GP was one of the key barriers in introduction of GP in undergraduate curriculum.[67] However, there is a consensus that a national curriculum should be developed that provides a sound understanding of primary care and also firm a firm foundation to those who choose to become GP. [68]

The shortage of primary care physician is alike in US, Australia, Canada, Norway and exposure of undergraduates to GP teaching has demonstrated an association to the entry in GP training which could alleviate the burden.[69,70] Thus, family medicine is an integral part of the required curriculum during the preclinical and clinical years as recommended by

American Academy of Family Physicians.[71] As per the data from Association of American Medical College 89% and 61% of medical schools had separate clerkship for family medicine and Emergency medicine respectively in 2020.[72]

As per our context, the need of GP in undergraduate education, teaching the particular skills of a family physician was realized much earlier.[73] Following which a qualitative study was done in 2010, with the aim to generate a framework for a core curriculum in General Practice in the undergraduate setting, specifically for Nepal. The findings were focused on identifying the key areas of knowledge, skill and attitude to be incorporated during medical school.[74]

General Practice and Emergency medicine has been incorporated in the curriculum of Patan Academy of Health sciences since the beginning of undergraduate program during the pre-clinical and clinical years with specified objectives and skills to be attained during the clinical rotation. There is also 20 weeks of rural posting under the supervision of General practitioner at the rural site.[75] Likewise, it is also included in the undergraduate curriculum of Tribhuvan University as Emergency medicine and Family practice.[76] Similarly, General practice and Emergency medicine is included in the curriculum of Karnali Academy of Health and implemented since the first batch of Bachelor of Medicine and Bachelor of Surgery.[77]

The national curriculum framework is being published by the Medical education commission in May 2023, which has included General practice and emergency medicine as key areas of learning with specified core competencies to be attained as the focus has now shifted to competency based learning.[78] Despite this, there is a lacuna in the inclusion and uniformity of curriculum in all existing medical schools of Nepal.

We need to work towards incorporating and implementing General practice and Emergency medicine in undergraduate curriculum in all medical schools as recommended by the National Curriculum Framework. Collaboration among academic institutions, healthcare professionals, policymakers, and relevant stakeholders should be encouraged to facilitate the successful integration of GP education into medical school curricula to overcome implementation challenges as per the curriculum framework. The barriers hindering the incorporation of GP into undergraduate education to maintain the uniformity among the graduates should be appropriately identified and addressed. Issues such as the lack of consensus on GP's role and limited GP programs in medical schools should be resolved through informed discussions and strategic planning. Ample opportunities are entailed for medical students to engage with GP teaching through clinical rotations, immersive experiences in primary care settings, and mentorship programs emphasizing the benefits of GP training in enhancing health outcomes and career satisfaction. Robust mechanisms are required for evaluating and monitoring the effectiveness of GP education initiatives within undergraduate medical programs. Collecting feedback from stakeholders to assess curriculum impact, identify areas for improvement, and implement necessary adjustments. Advocacy is essential for policy backing by the structured body like General practice and Emergency Medicine Association of Nepal at the national level to prioritize GP education and address the shortage of primary care physicians. Engage policymakers to emphasize the crucial role of GP in healthcare delivery and secure funding for GP training initiatives. Encourage ongoing research and innovation in GP education to identify best practices, assess outcomes, and explore innovative teaching approaches. Foster collaboration between academia and healthcare institutions to drive continuous improvement in GP training programs.

9. GPEMAN will emphasize the need for continuous skill enhancement to ensure the best practice and patient safety recognizing the continuous change of disease profile and patient needs in the population.

The study found that it's very important for General Practitioners (GPs) in Nepal to keep learning and updating their skills. As diseases change and new ones appear, GPs need to stay updated. Research says that training in evidence-based medicine (EbM) can improve knowledge and skills, but how well it's used in real life is still not clear.[79] Regular training programs, workshops, and updates help GPs learn about the latest medical developments. This helps them manage new and changing diseases better and provide high-quality patient care.

Ensuring best practices and patient safety is a key part of good healthcare. Continuous professional development through regular training and Continuing Medical Education (CME) sessions helps GPs use the latest evidence-based practices in their work. Quality Improvement (QI) science gives a systematic way to make and test changes using real-time data to make meaningful improvements. This focus on skill improvement helps GPs diagnose accurately, treat effectively, and improve overall patient outcomes, ensuring higher standards of patient safety.[80]

Regular training sessions are crucial for updating GPs on the latest medical techniques, technologies, and treatment protocols. These sessions provide opportunities for hands-on practice and skill refinement, which are essential for mastering new skills and procedures. CMEs offer ongoing educational opportunities that cover many topics relevant to everyday practice. The GPEMAN can organize CMEs that include lectures, workshops, case studies, and discussions led by experts, ensuring a comprehensive approach to continuous learning. Programs like a 1-year fellowship offer structured training, helping GPs develop skills to improve

services and work better across different organizations.[81]

Offering training and CMEs through both physical and virtual platforms ensures accessibility and convenience for all GPs, regardless of their location. Physical platforms provide hands-on experience and direct interaction with trainers, while virtual platforms offer flexibility and the ability to reach a wider audience. Virtual training, such as webinars, online courses, and virtual workshops, allow GPs to participate from remote locations or during their own time, maximizing participation and learning opportunities.

10. Standardize the specialty name reflecting the roles and responsibilities of GPEM in Nepal considering international norms

During the study period, few participants suggested revising the name of specialty that is as per the international practices and norms. World Organization of Family Doctors (WONCA) uses the term General Practitioners or Family Physicians synonymously. [82] In USA GPs are known by family physicians[83] and are recognized as ideal primary care physician.[84] In NHS system UK, General Practitioner is used.[85] In India [86] and Srilanka General Practitioners are called Family Physician.[87] In Nepal General Practitioner or General Practice and Emergency Medicine physician is used. General Practitioner and Family Physician are the common terms used in the international scenario to represent the job title of MD in Family medicine/General Practice. The General Practice and Emergency Medicine Association of Nepal can hold a discussion session to either continue the same name or make some changes.

Limitation of the Study

All interviews were done via video conferencing therefore, the reflexivity and reaction might have been difficult to capture.

CONCLUSION

The study identified ten themes which is the basis for further reformation of GPs in Nepal. Themes included GP roles and duties in the health care system, reformation in GP curriculum, areas of advocacy, changes in research and education, etc. GPEMAN needs to take lead to implement the study findings. Some of the themes may need further in depth study for further improvisation.

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Conflict of Interest

Authors declared no conflict of interest. Ethical issues (Including Plagiarism, Data Fabrication, and Double Publication) have been completely observed by the authors

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Consent for the Study

Virtual consent was taken from the participants using google forms.

Consent for Publication

All the participants and authors consented for the publication of the study.

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