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The Role of Primary Care Physicians (DLP) in Community Care

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Dokter Layanan Primer (DLP) or Primary Care Physician (PCP) is a newly introduced term by the Indonesian government in 2013 since the enforcement of Medical Education Law 20/2013. DLP is a physician who solidifies his/ her education and career in primary care. They have postgraduate medical training in primary care and are experts in this field. In most countries, to be a generalist physician practising at primary care facilities such as health centres and primary care clinics, medical school graduates have to take postgraduate medical training to be proficient in terms of knowledge and skills in primary care services. Family medicine is the main body of knowledge of the primary care postgraduate training program in those countries even though their graduates are called differently among countries. These physicians are called family doctors or family physicians in the United States of America (USA), general practitioners (GPs) in Commonwealth countries, *huisarts* in the Netherlands. In Indonesia, where social, economic, and cultural diversity is very high in various regions, in addition to Family Medicine, Community Medicine and Public Health body of knowledge are added into its primary care postgraduate training program for approximately 20%. As a result, Indonesian DLP has to have knowledge and skills in planning and implementing community empowerment for healthy living.

Who can be a DLP? Anyone who wants to pursue a career in primary care (not in a hospital) can be a DLP. They could be existing primary care doctors as well as fresh graduate doctors graduated from undergraduate medical school program with or without a graduate certificate in family medicine, who are interested in postgraduate specialist training in primary care. Hence, DLP training qualification level is equivalent to the training level of other specialists. The duration of training is three (3) years. Unlike other specialist training that requires their residents to leave their workplace during the training program,

DLP training participants may continue to work in their primary care workplace during their DLP education. If the participants are not previously employed, they will be placed in primary care facilities prepared and provided as DLP training facilities. Since DLP training is a new program in Indonesia and the vast number of currently practising physicians in primary care without having postgraduate training, the government decides a need of a transition period for DLP training till 2030. During this period, general practice physicians working in primary care for more than five years calculated before July 2016, can attend transitional 6-month training to be awarded as a DLP specialist. This 6-month training aims at shifting the paradigm from a curative into more promotive and preventive care. The transitional training participants are believed more skilful than fresh graduate doctors because they have gained knowledge and experiences from their previous practices. These experiences are recognised so that they are entitled to DLP degree similar and equal to the degree awarded to 3 years DLP training participants.

Why do physicians in primary care need to be more expert in promotive and preventive care? Let's have a look at what happens in primary care practice room to answer this question. When a patient comes to a primary care physician because of a complaint, such as a prolonged cough. As a usual practice, the physician will do anamnesis, check the patient's physical signs, and if necessary do laboratory tests and x-rays. After that, the physician will establish a diagnosis and develop treatment protocol, inform lifestyle modification and other things for patients to recover quickly from their diseases.

DLPs practice differently to the doctor above because they have been trained to become more promotive and preventive physicians. DLPs will explore more, not only limited to the impact of diseases on their patients but also on their families and communities. This practice is called patient-centred, family-focused, and community-

oriented approach to the DLP practice. In addition to the patient, DLPs will ask who else in their families are also coughing, where the patients live and go to work and how the patient's living environment can be predicted as the cough trigger. The DLPs will also think about other health risks for those patients related to their age and gender group, as well as assess the risks in their family. The DLPs will also explore the possibility of transmission of the disease to people around the patient and educate them with cough etiquette to prevent the spread of the disease. DLPs will ask whether the patient ever experience the same symptoms before, or has been given treatment for respiratory diseases or symptoms similar to the current condition. Patients' smoking habits will be assessed both as active and passive smoker. Any related symptoms leading to diabetes or allergies, or specific infectious diseases are identified. All these questions are intended to explore the patient's internal and external factors influencing their health. DLPs ask open-ended questions, communicate in effective and culturally sensitive manner. DLPs have a comprehensive and holistic medical record system that can be analysed and shows the internal-external factors influencing patients' diseases and illnesses. Thus, DLPs see their patients holistically, not only their biological problems but also their psycho-socio-cultural-spiritual problems related to their diseases and illnesses. As a result, DLPs are able to manage their patients comprehensively. Furthermore, DLPs are also competent in early diagnosis of diseases with minimal visible signs and symptoms. This is possible because of the careful investigation and analysis of internal and external factors influencing patients' health and wellbeing. This which in turn will enable DLP to intervene as early as possible so that the disease does not get worse, does not spread to other people around the patient's, the patient could be rehabilitated both physically, mentally and socially as early as possible and get their functions back as healthy as possible.

The DLPs are competent to practice holistically and comprehensively because they are trained to be proficient in early detection of diseases in primary care. They are also prepared to manage these diseases effectively and making an appropriate referral as early as possible if needed so that cases could be managed by specialists in hospitals efficiently because they can see these patients in an early state. Finally, DLPs are able to manage and maintain the stability of patients' condition after receiving treatment by specialists and being referred back to primary care facilities. Hence, DLP and hospital specialist can work collaboratively in managing these patients.

In addition, DLPs are also equipped with an effective communication skill with cultural sensitivity. These skills enable DLPs to effectively motivate patients and their families to improve their habits and environment so that they are not affected by disease suffered by their family member. The communication skills also help DLPs to motivate patients and their families to seek help as early as possible when symptoms occur. The cultural sensitivity also helps DLPs in motivating patients and their families to participate in popularising lifestyle changes in order to

prevent diseases and illnesses as experienced by patients.

In terms of the concept of community-oriented of DLP practice, DLPs will decide to do a community diagnosis when they find an increased prevalence of certain diseases in their practice. The community diagnosis will be conducted in collaboration with other health professions to identify what is happening to the community that leads to an increase in the prevalence of the disease. DLPs will investigate and analyse why do certain diseases exist in a community and not in other communities. DLPs have to be proficient in community diagnosis so that during their training they have to conduct community diagnosis activities repeatedly from planning to evaluation in collaboration with other professions in primary care. The community diagnosis activities assist DLPs in determining the underlying causes of public health problems and then developing and implementing appropriate interventions. To date, the majority of community interventions are conducted in the form of providing information on diseases for people. Unfortunately, the information provided is mostly general and normative. This practice happens because the intervention is not preceded by a community diagnosis that can enable healthcare personnel to do an assessment of information needed and suitable for the community and develop an appropriate intervention. As a result, the information delivered and delivery methods are often not appropriate for the need of the community, as well as with their culture. Besides, due to inappropriate delivery methods, the information is often misunderstood. The provision of information in accordance with the needs and culture of the community usually gives more impact than the normative and general one.

As an important element of health care system, the performance of health care services and programs should always be improved. While a weak performance of health care services or programs could be one of the findings of community diagnostic activities, it is important for DLPs to have knowledge and skills in program evaluation. Therefore, DLPs are trained to be proficient in conducting an effective and efficient program evaluation. DLPs can accurately identify and determine a program that needs to be evaluated in their institution in order to solve health problems of the community. Furthermore, the need to maintain the quality of care in the clinic, DLPs have been trained to implement the clinical service quality assurance program, enabling to carry out effective and efficient primary services in accordance with the needs of the community.

Similar to other medical specialisation, basic family medical sciences, community medicine, and public health, have been taught when they were studying in the basic medical education program. However, in order to become an expert in primary care, a physician should increase his/her knowledge and skills as a generalist for the public to get health care services from the experts in primary care. In fact, DLP is a medical specialisation that is an expert in primary care. On the other hand, other specialisations are expert in secondary and tertiary services.

As mentioned in the medical education law number 20 of the year 2013, that medical profession consists of doctor, DLP (Dokter Layanan Primer) or primary care specialist, and specialist-subspecialist. The law implies that Indonesians have the right to receive physicians service and DLP services in primary health facilities, and have the right to receive specialist and subspecialist medical services at secondary and tertiary health facilities.

Thus, based on explanations above and as mentioned in studies conducted in countries that have been served by primary care specialists, the roles of DLPs in the community are:

1. Fulfilling justice for the community in the field of health
2. Providing medical services that are relevant to the community needs
3. Emphasizing on improving health and prevention of disease

It is anticipated that the development of DLP training program in Indonesia could benefit Indonesian community. Indonesian will be served by primary care experts so that the needs of the healthy community can be fulfilled.

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