

Family-Centered Care: Beginning of a New Era in India

The concept of family-centered care (FCC) is entirely a new concept in neonatal care in India. We read the article by Verma, *et al.* [1], and would like to commend authors for their work. In many neonatal units in India, parents are not allowed to enter in neonatal intensive care unit (NICU), and others have fixed visiting hours. FCC is a partnership approach in which family and health care worker collaborate in decision-making and information sharing, and respect and honor differences. Partnership and collaboration, negotiation, and care in the context of family and community are key principles of FCC [2]. In countries like India where the health care professional to patient ratio is very poor, FCC can be a yardstick to improve care. FCC increases professional satisfaction and decreases litigation charges besides decreasing costs and effective utilization of resources [3].

We would like to highlight certain issues in present study [1]:

1. In index study, mean gestation was near term (36.4 weeks); however, in real life scenario, the majority of infants in NICU are preterms who need more dedicated care. Quite often, parents and/or health professionals are not confident in handling these babies. So, there is need to empower parents by more training.
2. In present study, mean time spent bedside by attendant was 14.7 hours/day. This long stay will lead to fatigue in attendants. So, we must objectively assess fatigue score as well as satisfaction level in attendants, and should collect feedback from them to make it more convenient for them.
3. The author stated that actual time spent bedside by an attendant in previous 24 hours was noted weekly by direct inquiry. This is prone to recall bias, and prospective documentation in parent contact sheet would have been better.
4. Exclusion of twins and triplets from the study does not seem to be rational, and it compromises generalizability of the study. In real life, we face feeding difficulties in most of these babies. There are ongoing studies with some evidence that group-caring and cot-sharing for twins/triplets improve behavioral and developmental outcomes. These are the families and babies who will be most benefitted with FCC.

Evidence shows that high-quality, family-centered care

during the hospital stay is associated with a significant reduction in nonurgent emergency visits in these children [4]. We are hoping same for these neonates, and expect further studies with large sample size, including preterm neonates and twins.

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AUTHORS' REPLY

We thank the authors for reading our pilot work on family-centered care (FCC) [1].

Elaborate discrete description of principles of FCC has existed in medical literature for over two decades [2]. However, there is hardly any literature about as to what constitutes translating and adapting principles of FCC into operational models of FCC into day to day practice. We translated and adapted principles of FCC to an operational model to empower and build competencies of parent attendants for essential caregiving skills to their sick neonates. Comprehensive audio-visual training modules were developed to achieve this in a standardized manner.

The present study that was conducted in 2010-12, was designed as an efficacy trial to test the intervention of FCC for impact on pertinent outcomes such as nosocomial infection rates (primary) and hospitalization duration, exclusive breastfeeding rates at discharge, and mortality (secondary outcomes) between the two groups. However after this preliminary trial, we have been working iteratively to develop a more pragmatic model of implementation that has been tested and found feasible across all stakeholders (nurses, doctors and parent-attendants). Presently FCC has become a standard of care practice in our NICU and allows flexibility with regard to

either wilfulness or extent of participation by the parent attendants. Our model recommends a checklist required for implementation of FCC including the need of mother-friendly facilities to enable her to rest and recoup besides being engaged in processes of care for her sick baby.

1. Being a preliminary pilot intervention study, we were conservative in our inclusion criteria. Thus we excluded hemodynamically unstable and critically sick babies as well as the multiple gestations, who were all predominantly preterms. This may be the reason of mean gestation in our study to be advanced. As such the proportion of preterms in our study was 28.8%.
2. The mean time spent bedside was shared between two to three attendants who took turns in a day per baby to spend this time with their babies. We do agree that spending this time with their respective baby could lead to fatigue. One may consider assessment of the same by incorporating fatigue scores in future studies as suggested by the authors.
3. We agree that noting actual time spent by the attendants prospectively in parent sheet would have reduced the recall bias. However, actual time spent by the attendants was not a primary/secondary objective, and hence was recorded in a feasible manner in this study.
4. Inclusion criteria in our study required presence of at least two accompanying attendants per baby. It would not be feasible to have four or six attendants available

(as would accordingly be required for twins or triplets respectively) to participate in caregiving from a family, and hence we excluded multiple births from the study.

Sure enough, we agree with the authors that FCC seems to be the beginning of a new era in India. Follow-up studies of the FCC cohorts will be important to document impact of this promising social collaborative partnership on neonatal outcomes. Evaluation of the method at scale is an implementation science question of some importance, in order to show that successful pilot studies in tertiary centers are not attenuated when scaled up through district facilities [3].

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When are we to Integrate 'Research Module' in Undergraduate Medical Curriculum in India?

We read with interest the recent perspective on lack of research amongst undergraduate medical students in India [1]. The authors propose possible solutions to improve research amongst undergraduates but the suggested interventions are not prioritized.

The medical education program in India, both at undergraduate and postgraduate levels, is not research-oriented. Whether research component should be made

an integral part of training is often discussed, debated and deliberated but not implemented [2]. This is probably because our undergraduate training program is 'primary-care physician' oriented and emphasizes patient care to a great degree. Nevertheless, our students, faculty as well as policy makers need to realize the relevance of 'routine research skills' to practice evidence-based medicine in 'primary care'.

We suggest that rather than emphasizing mandatory student research activity as an exposition, there is a need to adopt step-wise approach. Orientation to medical research and participation in research project are two distinct aspects (theory and practice respectively) of training in research. We contend that student orientation to research in medical science is the first step, which essentially is a curricular reform initiated at national level (by Medical Council of India) with the introduction of an 'Undergraduate Research Module'. Creation of an environment conducive to research and inculcation of