



Perceptions of Indian Medical Graduates on the Family Adoption Program: A Qualitative Study.

Mir Musharraf¹, Dr. Yasmeen Jan², Ishfaq Manzoor^{3*}, Raja Firdouse Bhat⁴, Nayar Muhammad Shah⁵.

¹MBBS Final Year Part 2, SKIMS MC Bemina Srinagar.

²Associate Professor, Department of Community Medicine SKIMS MC.

³Department of Central Library SKIMS MC Bemina.

⁴MBBS Final Year Part 2, SKIMS MC Bemina Srinagar.

⁵MBBS Final Year Part 2, SKIMS MC Bemina Srinagar.



Correspondence:

Ishfaq Manzoor.

Department of Central Library
SKIMS MC Bemina.

Email:

waniishfaq0001@gmail.com

Received: 16-03-2026

Revised: 06-04-2026

Accepted: 27-04-2026

Published: 12-05-2026

Abstract

Background: Purpose: This study aimed to evaluate the perceptions of MBBS students towards the new Family Adoption Program (FAP) in Jammu and Kashmir. The objective was to assess its perceived educational value and identify the primary implementation challenges from the students' perspective. **Methods:** A mixed-methods, cross-sectional design was employed. The study collected quantitative data via a survey from 354 MBBS students across various professional years in Government medical colleges of the Kashmir division. This was supplemented by qualitative data from 22 in-depth, semi-structured, face-to-face interviews to explore these perceptions in greater detail. **Results:** The findings reveal a significant paradox of "conditional support." Quantitatively, a majority of students (71.76%, n=254) reported a positive or very positive perception of FAP's potential impact. However, 61.30% (n=217) would only recommend it to future batches if significant improvements are made, compared to just 26.55% (n=94) who would recommend it without reservations. While 65.82% (n=233) found it beneficial for communication skills, its implementation is critically flawed. An alarming 85.60% (n=303) of students acknowledged that peers do not take FAP seriously, and 68.65% (n=243) reported observing fabrication of FAP reports. Qualitative analysis confirmed these findings, identifying critical gaps in pre-visit orientation and inconsistent faculty mentorship as primary drivers of peer disengagement and a perceived disconnect between effort and learning value. **Conclusions:** The Family Adoption Program is valued by students as a powerful pedagogical concept but is currently failing in its execution. Its potential to foster empathy and community-oriented skills is being critically undermined by systemic implementation failures, leading to widespread student disengagement. This study concludes that policy mandates alone are insufficient. Realizing FAP's promise requires urgent institutional investment in structured faculty mentorship, comprehensive student training, and robust logistical support. Future research should incorporate faculty perspectives and conduct multi-state comparisons.

Keywords: FAP, Medical Education, MBBS Students, Community-Based Learning.



This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC-BY) license (<http://creativecommons.org/licenses/by/4.0/>).

INTRODUCTION

The landscape of medical education in India is currently undergoing a major transformation with the implementation of the Competency-Based Medical Education (CBME) curriculum introduced by the National Medical Commission (NMC) in 2019.¹ This shift represents a transition from the traditional discipline-oriented teaching model to a more integrated and outcome-driven framework. A key component of this revised curriculum is the Family Adoption Program (FAP), which has been introduced as a longitudinal, community-based learning initiative for MBBS students beginning with the 2021–22 batch.^{2,3}

Under the Family Adoption Program, students are required from their first professional year to “adopt” several families, generally located in rural areas or underserved urban communities. This structured initiative facilitates continuous engagement with these families alongside the students’ academic progression up to the third professional year.^{4,5}

The foundation of this program lies in the recognized need to align medical training with the principles of social accountability and primary healthcare. The FAP draws inspiration from the well-established “Sewagram model” of community-based education developed at the Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram.⁶ This model emphasizes that understanding a patient’s health requires insight into their broader social, economic, and environmental context—an aspect that cannot be fully appreciated within hospital-based teaching alone. The distinct

strength of FAP lies in its sustained, long-term engagement. Unlike short-duration community postings, it aims to connect theoretical knowledge with real-world healthcare delivery.⁷ Through this continuous exposure, the program seeks to enhance students' comprehension of public health issues while fostering critical competencies such as empathy, holistic patient care, and effective longitudinal communication skills.^{1,2}

Despite its widespread adoption and promising objectives, a significant gap in evidence remains. Existing studies have largely concentrated on early implementation stages and immediate feedback from current students. There is a lack of comprehensive research that evaluates the cumulative and retrospective experiences of individuals who have completed the entire duration of the program. Addressing this gap is crucial, as medical graduates can provide a broader and more reflective perspective than current students. Having experienced the program in its entirety, they are better positioned to assess its progression—from initial challenges to its overall influence on professional development and preparedness for real-world practice. Consequently, this study contributes to the ongoing discourse on community-based medical education and offers practical insights that may assist educators and policymakers in India and other settings where similar initiatives are being implemented.⁷

In view of this, the present study was designed to systematically explore the in-depth perspectives of recently graduated doctors. Rather than merely quantifying perceptions, it focuses on understanding detailed experiential narratives, highlighting perceived strengths, identifying specific barriers, and evaluating the overall impact of the program on professional growth. The study seeks to answer the central research question: What are the experiences and perceptions of Indian medical graduates regarding the Family Adoption Program (FAP)? It is hypothesized that graduates perceive FAP as a valuable contributor to community orientation, empathy, and professional development, while simultaneously recognizing persistent challenges that necessitate structured interventions to optimize the program's effectiveness.

AIMS AND OBJECTIVES

The Study aims to assess Indian medical graduates' perceptions, challenges, and the impact of the Family Adoption Program (FAP) on their professional development. The study also aims to provide recommendations based on this feedback to improve the program's overall effectiveness.

Primary Objectives

- To explore the perceptions and experiences of Indian medical graduates regarding the Family Adoption Program (FAP).
- To assess the impact of FAP on the personal development and future professional acumen of medical students.
- To identify the challenges and barriers faced by medical students during their participation in the FAP.

Secondary Objective

- To provide recommendations for improving the implementation and effectiveness of the FAP based on student feedback.

METHODOLOGY

A mixed-methods sequential explanatory design was chosen for this study. The two phases comprise the entire approach. Next, in-depth, semi-structured interviews were held with a deliberately chosen sub-sample of participants to unearth, in-depth, and share the "why" behind the quantitative findings alongside the rich lived experiences of the participants. The study was carried out in different Government medical colleges located in the Kashmir division of UT of J&K. All the data gathering and analysis were done in three months from June 2025 to August 2025. The sample consisted of all medical students enrolled in the undergraduate (MBBS) program at the medical colleges that were selected.

Inclusion Criteria

1. MBBS students from the MBBS Phase I, II, III Part 1 (3rd Year) and III Part 2 (Final Year) who have adopted at least five families during their studies.
2. MBBS students who expressed their willingness to join the in-depth interview and who gave their informed consent to participate in the study.

Exclusion Criteria

All MBBS students who were enrolled before the FAP was introduced into the medical curriculum.

Sampling Method: Purposive sampling was applied. A subgroup of 22 survey respondents was selected from the 354 survey respondents to ensure that students from various professional years, colleges, and students with both highly positive and highly negative experiences on the survey were included.

Sample Size: A total of 22 semi-structured interviews were held for the purpose of determining when data saturation (the point at which new interviews do not bring up any new significant themes) would be achieved.

A semi-structured interview guide was created that was based on the study goals and an initial analysis of the survey data. A total of 22 participants were selected and asked to participate in a one-on-one interview. The principal researcher conducted all the interviews in person with the interviewee present in a quiet and private room to keep the conversation confidential. Each interview took approximately thirty to forty-five minutes, was recorded with the participant's knowledge and permission, and then transcribed word for word. The 22 transcripts which were prepared verbatim were subjected to analysis using Thematic Analysis. The qualitative data analysis software ATLAS. It was used to systematically arrange and control the text data. The analysis was conducted through a systematic process of (1) getting acquainted with the data, (2) developing initial codes, (3) looking for themes by classifying codes, (4) reflecting and polishing themes, and (5) determining and labeling the ultimate themes.

Ethical Considerations

Ethics Approval: The protocol of the study along with the data collection tools and consent forms received the approval of the Institutional Ethics Committee (IEC).

Permission: Administrative clearance was obtained from the Principals of all Government medical colleges that were part of the study.

Informed Consent: Informed consent was obtained from all the participants. In the case of the face-to-face interviews, separate informed consent was obtained through audio recording before the start of each interview.

Confidentiality: All information was anonymized and kept confidential. Personal identifiers were eliminated, and all information was kept on encrypted, password-protected computers. Pseudonyms are assigned to all direct quotes in the research findings to ensure the anonymity of the participants.

RESULTS

Comprehensive Thematic Analysis

Thematic Structure

Theme 1. Educational Benefits

Subthemes: Real-world learning; Clinical correlation; Social determinants understanding

Key codes: Disease burden recognition, Theory-practice integration, Population health perspective

Theme 2. Communication Skill Development

Subthemes: Confidence building; Cross-literacy communication; Language acquisition

Key codes: Overcoming shyness, Professional communication, Local language learning

Theme 3. Empathy Development

Subthemes: Understanding patient suffering; Recognizing barriers; Professional values

Key codes: Socioeconomic awareness, Patient-centered orientation, Compassion cultivation

Theme 4. Implementation Challenges

Subthemes: Training gaps; Mentor variability; Logistical barriers

Key codes: Inadequate orientation, Inconsistent supervision, Language/transport issues

Theme 5. Student Engagement

Subthemes: Variable commitment; Unclear objectives; Assessment influence

Key codes: Low peer seriousness (80%), Grading motivation, Casual attitudes

Theme 6. Community Acceptance

Subthemes: Gradual rapport; Visit fatigue; Reciprocity needs

Key codes: Initial hesitation, Relationship building, Repeated visit irritation

Theme 7. Enhancement Recommendations

Subthemes: Better training; Stronger mentorship; Improved logistics

Key codes: Comprehensive orientation, Equipment provision, Family rotation, Structured evaluation

Detailed Themes

Theme 1: Educational Benefits and Transformative Learning

FAP enabled students to apply theoretical knowledge in community contexts.

UG3 noted: "Hypertension is very common in rural Kashmir—prevalence around 60-65%."

UG11 stated: "The program allowed me to clinically correlate theoretical knowledge with real-life community situations."

Students recognized social determinants' impact, with UG20 observing: "There is a huge difference between what we learn from books and what actually happens in real life." UG21 demonstrated sophisticated understanding: "In public health, 'prevention is better than cure,' but once disease sets in, proper treatment becomes crucial."

Theme 2: Communication and Interpersonal Skill Development

Communication development was the most frequently cited benefit. UG2 shared: "Earlier, I used to be shy, but through this program, I gained confidence to interact with patients and families."

UG1 emphasized learning to communicate with "both literate and illiterate individuals."

Non-Native students like UG20 reported: "My communication skills improved significantly – especially speaking the local languages. Initially, I could not speak fluently, but interacting with families helped me gain confidence."

UG4 noted: "Initially, it was hard to approach unknown people, but gradually we learned how to speak respectfully and effectively."

Theme 3: Empathy and Professional Attitude Development

FAP fostered empathy through exposure to families' lived realities.

UG14 observed: "I realized how many health-related problems were linked to financial constraints, lack of awareness, and limited access to healthcare."

UG4 reflected: "Interacting with families helped me understand what patients actually need at the community level, not just in hospitals."

UG22 recognized: "Health is not just about disease treatment, but also about understanding the lifestyle, behavior, and living circumstances of the community."

UG6 noted the program helped students "become more compassionate and patient while dealing with people."

Theme 4: Implementation Challenges

Students identified significant implementation gaps. UG1 reported: "No training or guidance was provided before visiting families, which made the experience less structured and more confusing." Mentor involvement varied dramatically – UG1 noted "no proper mentorship," while UG10 praised "excellent guidance with pre- and post-interaction sessions." Language barriers affected non-local students significantly. UG8 stated: "The major challenge was the language barrier." Logistical issues included transportation difficulties, academic workload conflicts, and family unavailability. UG7 noted: "Coordinating visits was sometimes inconvenient due to distance and lack of transport facilities."

Theme 5: Variable Student Engagement

Peer engagement varied substantially. UG1 reported: "Around 80% of students do not take FAP seriously, while only a few are genuinely engaged." UG8 explained: "Most students did not take FAP very seriously, mainly because they were unsure about its purpose and long-term benefit." UG4 observed some "treat it casually, almost like an outing." UG14 noted grading influence: "Most students took it seriously primarily because it contributed to grading." However, engaged students like UG1 recognized "FAP has great potential in helping students understand real-world healthcare delivery, provided it is implemented with proper planning."

Theme 6: Community Acceptance and Family Dynamics

Family acceptance evolved over time. UG20 described: "In the beginning, families were very welcoming—'Doctor Sahib has come!' But after repeated visits, their enthusiasm reduced." UG19 noted: "Families sometimes become irritated by repeated visits." UG13 emphasized relationship depth: "I was able to build good rapport with family members. Over time, they became comfortable sharing their health issues, which made interactions more meaningful." The extractive nature of data collection without reciprocal benefit emerged as problematic. UG20 observed unintended consequences when distributing medicines: "Families kept demanding more simply because it was free."

Theme 7: Recommendations for Program Enhancement

Students provided constructive suggestions. UG5 emphasized: "There should be proper demonstrations before visits—showing us how to conduct interviews, fill forms, and perform basic examinations." UG4 recommended: "Hands-on training in basic clinical skills—measuring blood pressure, pulse rate—should be included before visits." UG1 advocated for "structured and continuous mentorship." UG2 suggested: "Students should get proper feedback and discussion sessions after each visit." UG19 proposed family rotation: "Families could be rotated after three to four visits to maintain interest and cooperation." UG11 recommended starting FAP in third year: "when students have a stronger medical foundation."

UG22 suggested: "Conducting medical camps in adopted communities in collaboration with health professionals." Despite implementation challenges, students overwhelmingly endorsed FAP with improvements. UG1 stated: "Yes, I would recommend it—especially if proper mentorship is implemented." UG8 offered: "Despite challenges, it's a good opportunity to gain practical experience." UG2 emphasized: "It gives students early opportunity to interact with communities and understand real health problems. It builds confidence and teaches empathy, which are essential qualities for any future doctor." UG15 concluded: "Despite shortcomings, it is very beneficial. It helps build communication skills, understand real-world healthcare challenges, and develop empathy and professionalism."

DISCUSSION

This study directly addresses this gap by focusing exclusively on this cohort and using an in-depth, qualitative approach to move beyond what participants perceive and explore how and why the FAP shaped their medical education. The qualitative interviews provided rich context for the findings. Students described FAP's transformative potential in three core domains: 1) educational benefits through real-world application of theoretical knowledge, 2) communication skill development across diverse literacy levels and cultural contexts, and 3) empathy cultivation through sustained exposure to families' socioeconomic realities.

Our qualitative findings strongly triangulate these data and provide an explanation. The thematic analysis identified "critical gaps in pre-visit orientation" and "inconsistent faculty mentorship" as primary demotivators. The interviews also revealed a "striking finding" regarding peer engagement: participants estimated that 80% of students were not taking FAP seriously, attributing this primarily to "unclear program objectives and a perceived disconnect between effort and learning value." Furthermore, the qualitative interviews explained the top challenge of "lack of family cooperation." Students described a "temporal evolution from initial enthusiasm to potential fatigue with repeated visits," highlighting the community's need for meaningful reciprocal engagement rather than extractive data collection. The qualitative interviews provided more detailed and sophisticated recommendations, reflecting a deep understanding of programmatic needs. These included: 1) comprehensive orientation with hands-on clinical skills training, 2) structured mentorship with regular feedback, 3) family rotation strategies to prevent community fatigue, and 4) robust evaluation systems.

CONCLUSION

This study successfully met its objective to assess student perceptions of FAP. Through qualitative analysis, it uncovered the underlying reasons for these challenges. It confirmed that while FAP is succeeding in instilling a sense of social responsibility, it is failing to provide the structured, supervised, and valued educational experience that students require. The importance of these findings is twofold. First, they serve as a critical alert that FAP, a cornerstone of the new competency-based curriculum, is at risk of becoming a hollow, "tick-box" exercise. The disconnect between the program's high-minded goals and its on-the-ground reality is creating cynicism among students and fostering a culture of academic dishonesty. Second, and more constructively, the findings provide a student-driven blueprint for reform.

This study concludes that policy mandates alone are insufficient; FAP's success depends entirely on institutional commitment, faculty development, and structural support. For future research, this study should be expanded. Multi-state studies are recommended to compare implementation challenges across different regions. Including faculty perspectives is essential to understand the institutional barriers to effective mentorship. Finally, longitudinal studies are needed to track students post-graduation, determining whether a well-implemented FAP translates into a more empathetic, community-oriented medical practice.

REFERENCES

1. National Medical Commission (NMC). Implementation of competency based undergraduate curriculum. Available from: <https://www.nmc.org.in/MCIRest/open/getDocument.pdf>
2. The National Medical Commission Act, 2019 No. 30 of 2019. The Gazette of India, Extraordinary Part II, Section I, Registered No. DL (N) 04/0007/2003-19. Dated 8.08.2019. <https://egazette.nic.in/WriteReadData/2019/210357.pdf>.
3. Misra B. Family Adoption Program Finds its Place in New MBBS Curriculum. Medical Dialogues. 17 April 2022. <https://medicaldialogues.in/news/education/family-adoption-programme-finds-its-place-in-new-mbbs-curriculum-91556>.
4. Dey S. NMC may make family adoption programme part of MBBS training. Times of India. 16 February. 2022. <https://timesofindia.indiatimes.com/india/nmc-may-make-family-adoption-programme-part-of-mbbs-training/articleshow/89601993.cms>.
5. Mennin S, Mennin R. Community-based medical education. Clin Teach. 2006;3:90–6
6. Kasturba Health Society's. Mahatma Gandhi Institute of Medical Sciences. "Community Based Medical education". <https://www.mgims.ac.in/index.php/community/community-based-medical-education>.
7. Shree A, Rashmi S, Kumar SD. Community as a classroom: Perception of an Indian medical graduate on Family Adoption Program. Clinical Epidemiology and Global Health 2024; 28(2): 101630. DOI:10.1016/j.cegh.2024.101630.