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The Current Situations and Problems of Family Physicians in the Province of Kayseri and Their Views about the Family Medicine System

ORIGINAL INVESTIGATION

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ABSTRACT

Objective: The purpose of the study is to determine the current situations and views of family physicians in Kayseri province about the family medicine system.

Materials and Methods: This study, carried out in Kayseri province in 2012, administered a questionnaire to 325 family physicians.

Results: The top reasons for preferring to be a family physician are the desire to be in the new system, high income, and the view that it is more prestigious than being a general practitioner. Also, 44.9% of the physicians stated that they were worried about the exit of enrolled people from their list, and 42.8% of them stated they are worried about other physicians' desire to take their population; 63.8% of them stated that the system caused moral corruption, and 43.3% of them stated that it ruined the team approach. Almost half of the physicians (45.9%) stated that the family medicine system caused anxiety for the future, and 42.3% of them mentioned that it affected their personal rights negatively. The physicians claimed a mostly unnecessary medical report (92.5%), prescribing medicine without seeing the patient, and facing requests of prescribing unnecessary medicaments as problems. One-third of the physicians believed that the system increased drug consumption. The rate of physicians who believed that the system increased workload was 73.0%; 52.7% of the physicians were content with working in the family medicine system. The only factor affecting the contentment of the physicians with working in the system according to the logistic regression analysis was thinking that it was prestigious to work as family physicians.

Conclusion: Half of the physicians were satisfied with working in the system. They thought of the improvement of factors providing patient satisfaction as a positive aspect of the system and an increasing work load, corruption, and the increase in the use of medicaments as negative aspects.

Key words: Family physicians, family medicine, view

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INTRODUCTION

Studies advised by the World Bank in the 1990s that began in this period were called "Healthcare Reform" and have been called the "Health Transformation Process" since 2003. Notwithstanding that the "Health Transformation Program" has not been completed in our country, the fastest title put into practice was passing to "family medicine" system in the primary healthcare. The extension of the family medicine system to all provinces is among the leading targets of the 9. Five-Year (2007–2013) Development Plan (1). "Family Medicine Implementation in Primary Healthcare" started with "The Law numbered 5258 about Family Medicine Pilot Implementation" in Düzce province in 2005 and was put into practice all over Turkey on 13.12.2010 (2). A radical transformation process is being experienced in primary healthcare services in Turkey by this implementation, which restructured the primary healthcare system. With this implementation, the process of "healthcare socialization" that started in the 1960s, when a social state approach was put into the constitution, came to an end.

The primary healthcare service is an indispensable part of healthcare systems of countries (3). This service is provided distinctively in different countries in the world. With passage of the implementation of family medicine in our country by "The Law numbered 224 about Socialization of Healthcare Services," health houses and health centers under the healthcare service institution gave way to family and community health centers. Healthcare services for individuals are provided in "Family Health Centers" (FHCs), and healthcare services for society are provided in "Community Health Centers" (CHCs). According to the update of the Turkish Public Health Institution Family Physician Monitoring and Evaluation Directorate on May 25, 2012, 20,503 family physicians are working in 6524 FHCs. In addition, there are 957 CHCs.

In the Health Ministry Family Medicine model, it is stated that primary healthcare services are reorganized with a contemporary approach and extended, and primary healthcare services are provided in such a way that individuals prefer them. The main factors of this approach are the existence of family physicians that everyone can prefer and have access to easily (6). The implementation of primary healthcare family medicine in our county is constructed

as a system rather than a specialty; thus, general practitioners or specialist physicians receiving the training envisaged by the Health Ministry are accepted to be family physicians. According to the law numbered 5258, the services to be provided by family physicians and family health staff are healthcare services that are protective for the individual and primary diagnostic, medical, and rehabilitative care (2).

It is explicit that not being able to provide the services appropriately, lack of coordination, and problems in the work environment may lead to ineffective and inefficient use of the resources and thus dissatisfaction of employees and patients. In order to provide the appropriate service, the problems should be recognized when they first emerge and are taken into consideration. The family practice was first begun in Kayseri province in December 2008. In this study, we aimed to determine the current situations of family physicians working in Kayseri, the problems they encounter in practice, and their views about the system in a descriptive study.

MATERIALS and METHODS

This study was a descriptive survey carried out in Kayseri between January and March 2012. It planned to involve all 368 family physicians working in the province. The questionnaire forms prepared by the surveyors were sent to 53 FHCs, and 325 family physicians filled the forms and sent them back; 43 of the physicians (11.7%) were excluded from the study due to reasons, such as being on vacation and not willing to participate. The rate of reaching the physicians was 88.3%. In the preparation stage of the questionnaire, it was benefited from the concerned literature and the views of physicians. There are 44 questions in the questionnaire, and it is divided into two parts. The first part includes some data about demographic and socio-economic features of the physicians. The second part includes questions about reasons for preferring to be a family physician, the workload in family medicine, their worries and problems they encounter, their views about the system, and their state of satisfaction with being in the system.

Before conducting the questionnaire, a pre-application was performed for 10 physicians who worked as family physicians before but left for some reason. Considering the problems encountered during the application and recommendations, the questionnaire form was reorganized and finalized. The study was approved by the Erciyes University ethics committee.

Statistical analysis

In the presentation of the data, frequency tables were used for qualitative data, and chi-square test was used for categorical data. Logistic regression analysis was performed to determine the factors affecting the satisfaction of family physicians. The physicians who were very satisfied and satisfied with working in the family medicine system were categorized as "satisfied," and those who were not satisfied, not satisfied and indecisive were categorized as "not satisfied." Age, total period of service, and working period as a family physician were taken as continuous variables. A p value <0.05 was accepted to be statistically significant.

RESULTS

The family physicians' ages were between 29-60 years, and their mean age was 41.9±5.5. Their service periods varied between 4 and 32 years, and their mean service period was 16.8±5.4 years. The distribution of socio-demographic features is indicated in Table 1.

The mean service periods at the last institutions at which they worked were 8.5±5.9 years for health centers, 8.3±6.8 years for tuberculosis control dispensaries, 7.5±5.0 years for hospitals, 6.4±4.0 for health directorates, and 5.3±4.6 years for 112 emergency services. Also, 64.9% of the physicians' service periods were 15 years and over; 56.1% of the family physicians were graduates of Erciyes University Medical Faculty. Further, 26 of the family physicians (8.0%) were specialist physicians, and 15 of them (4.6%) were family physician specialists.

The reasons for preferring to become a family physician are given in Table 2.

The top three reasons of preference were the desire to take part in the system, high income, and prestige. The distribution of features of the health staff with whom the family physicians worked is indicated in Table 3, and the distribution of whether the physicians provided protective healthcare services or not apart from outpatient clinical service is indicated in Table 4.

Table 1. The distribution of socio-demographic features of the physicians

Features	Number	%
Gender (n=325)		
Male	225	69.2
Female	100	30.8
Marital Status (n=321)		
Married	300	93.5
Single	21	6.5
Total service period (n=322)		
0-4 years	1	0.3
5-9 years	22	6.8
10-14 years	90	28.0
15 years and over	209	64.9
The last worked institution (n=313)		
Health Center	153	48.9
Public Hospital/Maternity Hospital	106	33.9
Other	54	17.2
The institution at which they worked for the longest period of time before being a family physician (n=316)		
Health Center	156	49.4
Public Hospital/Maternity Hospital	96	30.4
112	9	2.8
Health Directorate	14	4.4
Other (mother and child care and family planning centers, tuberculosis dispensary, private hospital, etc.)	41	13.0

Table 2. Reasons of physicians for preferring to be a family physician

Preference Reasons (n=325)	Number	%
The desire to be in the new system	178	54.8
High income	147	45.2
Its being more prestigious than general practice	87	26.8
Desire to work in a city center	33	10.2
Not being satisfied in the workplace	27	8.3
Miscellaneous	61	18.8

The mean population that the physicians had to follow was 3492±505, and the populations varied between 1520 and 4922. Daily average outpatient treatment numbers were 56.4±21.6; 81.2% of the physicians did not change their places which the Health Directorate determined when passed to the family medicine system for the first time. Half of the physicians thought that the registered population was sufficiently under their control. The population of the physicians and their views about the service are indicated in Table 5.

The distribution of the views of family physicians about the effect of the system on working life and personal rights and their worries are indicated in Table 6.

It was requested that the family physicians compare the protective and medical healthcare services with the previous system, and the percentage distribution of their replies is indicated in Table 7.

With regard to the physicians' evaluation of every protective and medical service indicated in the table according to the institutions at which they worked and their period of service, there was no significant difference ($p>0.05$). When the family physicians were asked whether they had the stated problems or not, the distribution of the replies of those who mentioned that they did is indicated in Table 8.

The most common problems that the physicians faced were unnecessary medical reports, requests for unnecessary medication prescriptions, and requests for medication prescriptions without seeing the patient.

In total, 5.0% of the physicians were very satisfied, 47.7% of them were satisfied, 26.5% of them were neutral, 15.9% of them were not satisfied, and 5.0% were very dissatisfied. Logistic regression analysis results of the factors that may affect the satisfaction levels of physicians are given in Table 9.

Age, total period of service, the period worked as a family physician, gender, and the previous institution's being a primary healthcare center or not did not affect the physicians' satisfaction levels. The physicians' preference for becoming family physicians for its being prestigious was the only factor affecting their satisfaction levels.

When they were asked to what extent they found family medicine practice of the Health Ministry successful, 8.8% of the physicians stated that they found it definitely successful, 23.3% of them found it to be successful, 53.6% of them found it to be partly successful, 8.8% of them found it to be unsuccessful, and 4.1% found it to be definitely unsuccessful; 1.3% of the physicians did not comment.

Table 3. The features of the health staff with whom the family physicians are working

Features	Number	%
Gender (n=322)		
Male	19	5.9
Female	303	94.1
Occupation (n=322)		
Midwife	235	73.0
Nurse	73	22.7
Other	14	4.3
Whether the family health staff that the physician is working with changed or not (n=325)		
Changed	135	41.5
Unchanged	190	58.5
Whether the family health staff worked in the same region before or not (n=319)		
Worked	150	47.0
Not worked	169	53.0
Work carried out by the family health staff during patient treatment in the outpatient clinic (n=313)		
Patient record		
Always	17	5.4
Sometimes	89	28.4
Never	207	66.1
Prescription entry		
Always	8	2.6
Sometimes	41	13.1
Never	264	81.2
Writing medical report		
Always	7	2.3
Sometimes	34	11.0
Never	272	86.7
Measuring tension		
Always	86	27.6
Sometimes	161	51.3
Never	66	21.1

DISCUSSION

The main purpose of the HTP, having been implemented since 2003, is to improve the state of individuals forming the society and, particularly, to improve the state of patients and health staff (7). In evaluating this process, identification of the operation of the system and the determination of problems and views of the physicians in the system are substantial sources of data.

Table 4. The distribution of whether the physicians provide protective healthcare services except outpatient clinic services or not

	I never provide		I help the family health staff	
	Number	%	Number	%
Vaccination (n=296)	162	54.7	134	45.3
Baby follow-up (n=310)	37	11.9	243	88.1
Pregnant follow-up (n=312)	49	15.7	263	84.3
Postpartum follow-up (n=306)	66	21.6	240	78.4
Female follow-up between the ages of 15-49 (n=310)	65	21.0	245	79.0
Family planning (n=308)	47	15.3	261	84.7

Table 5. The population that physicians provide pervice to and their views about service conditions

	Number	%
Whether the family physician changed regions or not (n=319)		
Changed	60	18.8
Not changed	259	81.2
The satisfaction level of the physicians from the population they are responsible for (n=323)		
Satisfied	148	45.8
Partly satisfied	159	49.2
Not satisfied	16	5.0
The views of the physicians on whether the population they are responsible for are under their control or not.		
Under my control sufficiently	164	50.5
Partly under my control	138	42.5
Not under my control sufficiently	15	4.6
Whether the physicians make house calls or not*		
I do not	32	9.8
I do	293	90.2
To the old	108	36.7
To the pregnant	80	27.3
To emergent patients	80	27.3
To sick abed patients	261	89.1
The physicians' evaluations of the physical conditions of the family health centers they are working at (n=325)		
Very good	49	15.1
Good	133	40.9
Fair	110	33.8
Bad	33	10.2
The room conditions that the physicians work in (n=320)		
In the same room with the family health staff	215	67.2
Have separate room	105	32.8

*The percentages of the physicians making house calls (293 family physicians) are calculated.

Table 6. The distribution of the views of physicians about the system, the system's effect on working life and personal rights, and their worries related to the system

	Number	%
Their views about the system (n=319)		
It is appropriate for our country.	163	51.1
It has raised the health level of society.	188	59.3
It has facilitated access of patients to physicians.	298	93.1
It has improved patient-physician communication.	228	70.8
It has enhanced healthcare quality.	212	66.3
It has increased continuity of service.	258	79.9
It has raised patient satisfaction.	270	83.6
It has enhanced data reliability.	232	71.8
It has not deteriorated the approach that the family is a whole.	193	81.2
It has increased medication consumption.	200	62.9
Their views about its effects on working life.		
It has increased working efficiency.	185	58.9
It has ruined the team approach.	139	43.3
It has deteriorated communication among physicians.	186	58.1
It has deteriorated communication between physicians and assistant health staff.	107	33.2
It has deteriorated communication among assistant health staff.	120	37.6
It has caused competition among physicians.	250	77.9
It has caused moral corruption.	206	63.8
It has increased my work load.	235	73.0
It has increased my stress related with the work.	219	68.0
It has increased my daily/monthly work hours.	181	56.4
It has enhanced my worries about the future.	147	45.9
It has affected my psychology negatively.	140	44.0
Their views about the system's effects on personal rights.		
It has affected my personal rights negatively.	132	42.3

Table 6. The distribution of the views of physicians about the system, the system's effect on working life and personal rights, and their worries related to the system **(Continue)**

	Number	%
It has not affected my personal rights.	126	40.4
To take a medical report in case of disease has become difficult.	193	60.5
Taking time off in case of disease has gotten difficult.	202	62.9
To join meetings for career development has become difficult.	177	55.3
Worries experienced.		
Peoples exiting from the list. (n=311)	146	46.9
The desire of other physicians to take his/her population. (n=319)	139	43.6
The desire of his/her other family physician friends working in the same FHC to take his/her population. (n=313)	77	24.6
The health staff quitting. (n=311)	43	13.8
Their views of quitting to work as a family physician (n=319)		
I am planning to do so.	68	21.3
I do not have such a plan.	171	53.6
I am neutral.	80	25.1
Regretting/disappointed to be in the system (n=309)		
Yes	113	36.6
No	196	63.4

*The percentages of the physicians making house calls (293 family physicians) are calculated.

Table 7. The health physicians' comparison of protective and medical services with the previous system (%)

Services (n=323)	Became better	Became worse	No change
Medical services	63.4	6.9	29.7
Vaccination services	80.2	3.4	16.4
Baby follow-ups	83.9	3.1	13.0
Child follow-ups	79.6	3.7	16.7
Pregnant follow-ups	84.2	3.1	12.7
Postpartum follow-ups	82.6	2.5	14.9
Family planning services	72.4	5.6	22.0
Consulting services in family planning	74.9	4.0	21.1
Home care services	64.7	3.8	31.6
Health education	55.6	6.9	36.6
Chronic patient follow-up	72.9	3.1	24.0
Services for early diagnosis	68.2	3.7	28.1
Geriatric health services	63.4	3.7	32.9

Table 8. The distribution of problems faced by family physicians

Problems (n=323)	%
Requests for unnecessary medical reports.	92.5
Requests for medication prescription without seeing the patient.	91.5
Requests for unnecessary medication prescription.	90.6
Requests for medical reports without examination (driving license, working in drudging jobs)	88.7
Lack of coordination between the Health Ministry and Health Directorate	71.8
Monetary cuts	70.8
Vaccination and medical dressing of people not enrolled on my list	68.1
The problems encountered with the Health Directorate (inspection, documents, etc.)	67.5
Out-of-pocket expenditures for service	54.9
Problems in supplying material and equipment	50.9
Problems among the physicians in FHCs	48.4
Problems about the health staff in FHCs	43.0
Problems about the use of shared areas	31.8
Problems about the use of computer programs	38.1

It was detected in the study that half of the physicians in the research group worked in primary healthcare (health center, tuberculosis dispensary, mother and child care, and family planning centers) before becoming family physicians, and the other half worked in institutions (hospital, administrative units) other than primary healthcare. In a study conducted on family physicians, similarly, half of the family physicians came from institutions other than primary healthcare (8). It was observed in our study as well that the average service periods of physicians who stated that they came from institutions other than primary healthcare were long. It is thought that it is not easy for physicians who have been away from primary healthcare for a long time and who have had little experience in primary healthcare to adopt and practice the approach of evaluating the individual in his psychosocial environment comprehensively. The high average daily patient number (56 people) was a factor that made the process difficult. Moreover, it is necessary to investigate the negative impact of departing staff who have worked at hospitals, dispensaries, and 112 emergency services for a long time and gained special experience on services.

Among the reasons for preferring to be a family physician, the top three were the desire to take part in the new system (54.8%), high income (45.2%), and having more prestige as a family physician than a general practitioner (Table 2). In a study conducted in Eskişehir, 48.1% of family physicians stated that they preferred to be a family physician, since it provided better practice conditions (9). In a study conducted in the provincial center of Afyon, 64.4%

Table 9. Logistic regression analysis results of the factors affecting the satisfaction levels of physicians with working in the system

	Beta	OR	%95 CI	p
Age (year)	0.029	1.030	0.929-1.141	0.575
Total service period (year)	-0.042	0.959	0.864-1.065	0.435
Service period worked as a family physician (year)	0.173	1.189	0.963-1.468	0.107
Gender	-0.318	0.727	0.422-1.254	0.252
The last institution worked at being a primary healthcare center	-0.102	0.903	0.553-1.474	0.683
Preference because of high income	0.239	1.270	0.764-2.112	0.356
Preference due to high prestige	1.188	3.280	1.820-5.913	<0.001
Constant	-1.991	0.137		0.180

of the participants stated that they preferred to be family physicians for social and economic reasons (8). In another study by Aktas, the majority of the physicians stated that they preferred being family physicians due to the high income (10). In studies performed in Eskisehir in 2010 and in Afyon in 2011, as well, the physicians mentioned that they were content with their income (8, 9).

While high income was an important reason for preferring to be a family physician at the beginning, income falls over time due to many factors, such as expenditures of FHCs, cuts due to performance, and a decreasing number of patients because they switch to another physician. Thus, 70.8% of the physicians in our study considered monetary cuts as problems, as did 54.9% for out-of-pocket expenditures for service (Table 8). In our study, it was also seen that the physicians had some worries about family medicine practice (Table 6). Almost half of the patients stated that the practice affected their psychologies negatively, and again, half of them stated that their anxiety about the future increased. The rate of those thinking that their stress and workload increased was also high. Moreover, the physicians had also anxieties about people exiting from their list and other physicians' desire to take their population. Two-thirds of the physicians thought that the system caused moral corruption. If the reasons for these problems are not investigated and eliminated, conducting the practice healthfully will not be possible and job satisfaction can not be provided, and the practice will increasingly become a problem in the future due to dissatisfaction and exhaustion.

In this research, conducted after a 4-year practice, 36.6% of the physicians stated that they felt regret/disappointed to be in the system (Table 6). In the study of Aktas, 24% of the participators replied "no" to the question "If you had a chance to choose again, would you prefer to be a family physician again?"; 21.3% of the physicians in our study stated that they thought of quitting family practice, and 25.1% of them stated that they were indecisive about it. This rate is similar with the study conducted in Eskişehir (9). In the following studies to be planned, it is important to follow these rates and investigate the reasons.

The physicians' having become contractual brings about some losses in their personal rights. In research carried out by the Health Ministry, it was seen that family physicians did not take kindly to working on a contractual basis (11); 42.3% of the physicians knew in our study that their personal rights were affected negatively by the family medicine system. However, 17.3% of the physicians stating that the system affected their personal rights positively and 40.4% of them stating that there was no effect, indicating that they are not aware of the loss of their rights.

In the system, a family physician works with at least one family health staff (FHS). The FHS is the nurse, midwife, or health officer working with the family physician on a contractual basis or charged by the Health Ministry. The FHS provides protective, medical, and rehabilitative healthcare services with the physician for people and keeps the health records of people and statistics (4). It was seen in this study that almost three-fourths of the physicians worked with midwives. Almost half of the FHSs (47%) were those that worked in the same region. It can be thought that it is advantageous for physicians to work with midwives with regard to follow-ups and family planning services. However, with more than half of the FHSs from the beginning of the system quitting and more than half of FHSs working in regions where they did not work before, problems might be caused in controlling the population and follow-ups. In our study, it was seen that FHSs sometimes worked in providing medical services (Table 3). When the fact that the average daily patient admission number was above 50 is taken into consideration, it will be quite difficult for FHSs to go out of health centers and to do detection, follow-up, and health training. For this reason, it may be thought that only people who are admitted by FHCs are provided protective medical services. In a study conducted in Kayseri in 2012, that 87.6% of persons state that they were not visited at home by FHSs supports our finding (12). Indicating the data concerning follow-ups by field surveys will allow us to reach healthier results.

Taking responsibility and providing continuous service for individuals in sickness and health, except treatment, are included in the job definition of family physicians (13). Family physicians bear the responsibility of making house calls in addition to pregnant, baby, and child follow-ups; vaccination; and family planning services. The provision of these services in real terms is possible when the physicians know that these services are not only duties of FHSs but also their main duties and undertake them. In our study, 21.0% of the physicians stated that they have never followed up females between the ages of 15-49, 15.7% of them stated that they have never followed up pregnant women, and 11.9% of them stated to have never followed up babies. At the same time, it was seen that the physicians had never made house calls (Table 4, 5). Almost

all of the physicians stating that they had made house calls stated that they visited old and sick abed patients. It is a discrepancy that the physicians believed that protective healthcare services were improved compared to the previous system (8, 10, 14, 15). Concurrently, half of the physicians thinking that the population that they were responsible for were partly or insufficiently under their control is an indicator that they provide services based on admittance.

Half of the physicians in our research group thought that the family medicine system was appropriate for our country (Table 6). The physicians believed that the system facilitated patient access to the physician (93.1%), increased patient satisfaction (83.6%), enhanced continuity in service (79.9%), and improved patient-physician communication (70.8%). Other studies carried out on this subject also support these results (8, 10, 14-16). The physicians stated that writing mostly unnecessary medical reports (92.5%), medication prescriptions without seeing the patient (90.6%), and requests of unnecessary medication prescriptions were problems (Table 8). When the Health Ministry started this practice, it was envisaged that unnecessary health expenditures and agglomeration of patients in secondary healthcare would be prevented. However, it is apparent that this was not realized as envisaged, since there was no referral obligation. Two-thirds of the patients (62.9%) believed that the system led to an increase in medication consumption (Table 6).

According to the logistic regression analysis, the only factor affecting the satisfaction of physicians with working in the system was the thought that family practice was more prestigious. Age, total service period, service period worked as a family physician, gender, and the institution's being a primary healthcare center did not affect the satisfaction level (Table 7).

CONCLUSION

When the views of physicians working in FHCs where primary healthcare service is provided in the family medicine system in Kayseri about the positive and negative aspects of the practice are taken into consideration, "the improvement of factors providing patient satisfaction and high income" were positive aspects, and "unnecessary patient requests, increase of work load, stress, and medication consumption" were negative aspects. It was detected that family physicians who were expected to provide coordinated and comprehensive lifetime health care service for people and their families provided service based on admission rather than their roles of protecting and improving the health of people. This study only reflects the views of family physicians about the family medicine system; thus, it is recommended that more comprehensive studies reflecting the views of all physicians working in secondary and tertiary healthcare services be conducted. Due to the fact that the number of family physicians was very few, the views of general practitioners and specialist physicians could not be compared.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Erciyes University.

Informed Consent: Written informed consent was obtained from patients who participated in this study.

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