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Satisfaction with Family Medicine Training in Turkey: Survey of Residents

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Aim. To explore how satisfied family medicine residents are with their training in teaching hospitals and current postgraduate training program.

Methods. We surveyed 135 family medicine residents in 5 teaching hospitals in Ankara region. The residents were asked to fill out the questionnaire at their work place. The questionnaire consisted of 23 open- and closed-ended questions about general demographic data, training conditions, appropriateness of training, and quality of training delivered by clinical teachers in family medicine. The response rate was 75%.

Results. Seventy percent of respondents found the order of rotation important. Most residents were satisfied with the duration of rotation. Eighty two percent of residents found basic skills taught during the course of the training to be insufficient. Fifty five percent of the participants felt that training in teaching hospitals was not sufficient, and majority desired training in family practice settings. Ninety-nine respondents suggested establishing a coordinating center for family medicine training and training of clinical teachers in topics relevant to family practice.

Conclusion. Family medicine residents were generally dissatisfied with their training in major teaching hospitals in Turkey. Postgraduate family medicine curriculum needs to be changed and opinions of residents regarding their training should be taken into consideration.

Key words: *attitude of health personnel; curriculum; education, medical, postgraduate; faculty, medical; family practice; internship and residency; physicians, family; primary health care; Turkey*

The contribution of family physicians to the health care system is undisputable. Their ability to use biopsychosocial model to provide comprehensive high-quality health care in a variety of settings to people with a broad array of health-related conditions is unique (1). Family physicians in primary care deal with undifferentiated health problems, comprehensive care, continuous patient care, and coordination of essential medical, social, and psychological services through referral and consultation (2).

In Turkey, family medicine became recognized as a medical specialty in 1984 and the first curriculum dates back to this time. A year later, teaching hospitals began with family medicine specialty training program (3). Teaching hospitals in Turkey are non-university hospitals, in charge of postgraduate training in various clinical specialties. The teaching staff is composed of medical specialists with the title of clinical chief or clinical chief deputy. Such hospitals are located in the largest 4 cities of Turkey (Istanbul, Ankara, Izmir, and Adana) and most family medicine specialists receive their training there. After the Higher Council of Education had recognized family medicine as an academic discipline in 1993, family medicine departments were founded at all university medical schools. Thereby, family medicine specialists could pursue academic careers (3). A small number of future specialists in family medicine are trained in these institutions.

An eligible candidate for the residency in family medicine in Turkey must be a medical graduate who has finished the 6-year medical undergraduate education program and passed an examination to be allocated to a training place. Physicians who wish to become family practitioners can complete their three-year formal residency either in a university medical school or teaching hospital. This formal postgraduate education in family medicine requires training in 5 different medical fields (5 mandatory rotations): internal medicine and pediatrics (minimum 9 months each), gynecology and obstetrics (8 months), general surgery (6 months), and psychiatry (4 months). During the rotations in training hospitals, the residents spend extensive time working at in-patient departments and fewer hours working in the out-patient clinic. A family medicine coordinator, who is a clinical specialist in one of the above clinical fields, supervises the whole training process. Every clinical chief is responsible for the training of family medicine residents at his or her clinical department. The coordinator determines the order of the rotations and the hospital departments where the residents are re-

ferred. After completing these 5 rotations and preparing a dissertation thesis, a family medicine resident is awarded the title of specialist in family medicine by the Ministry of Health.

To produce a competent family physician, residency programs should primarily aim at developing primary health care skills (4). However, it seems that graduate medical education fails to adequately prepare family physicians because they neither fully understand the health care environment nor know how to work efficiently within it (5). Traditionally, clinical teaching was always strongly related to hospital medicine. Future physicians learned their skills in hospital settings, by taking a patient's medical history, performing physical examinations, and making diagnoses. The teachers were clinical professors and specialists working in hospitals. Rapid growth in knowledge, supported by technological development, has led to subspecialization of medicine and clinical practice. In this context, family physicians in Turkey have become dissatisfied with their postgraduate education because the experience and skills they gain in teaching hospitals are quite different from those a family physician in primary care is required to have (6).

The same applies to Turkish teaching hospitals, where the majority of family physicians are trained. Residents in family medicine do not have any opportunity to work as general practitioners because there are no family practices or general practitioner surgeries in Turkey. Therefore, they have to complete their postgraduate training in hospitals as senior house officers or residents.

Primary health care is provided by health posts and health centers. Health posts are located in villages, run by a midwife, and serve a population of 2,500-3,000 people. Health centers are located in bigger settlements (5,000-10,000 people) and are staffed with physicians (mostly without special training), nurses, midwives, and health technicians. Family medicine departments at university medical schools are trying to change this situation by allowing their residents to receive training relevant to family medicine in primary health care centers. But the number of such training posts is small (7-8%). Thus, most family physicians are trained in teaching hospitals, where basic skills needed in family medicine are less addressed.

The curriculum of postgraduate training in family medicine is also strongly criticized. More and more family physicians claim that this postgraduate training fails to prepare them for the practice in primary care. The aim of this study was to explore what family medicine residents think about their training in teaching hospitals and about the current curriculum of postgraduate training program in family medicine.

Subjects and Methods

We surveyed 135 family medicine residents in five teaching hospitals of the Ministry of Health within the Ankara region. All residents were asked to fill out a questionnaire at their workplace.

A total of 101 residents (response rate 75%) completed the questionnaire. Fifty-two (52%) were women and 49 (48%) were men. The average age of the respondents was 31.0 2.8 years. Sixty-four (63%) residents were married, 36 (36%) were single, and 1 (1%) was divorced. Sixty-nine (68%) were third-year residents, 26 (26%) were second-year, and 6 (6%) were first-year residents. Sixty (59%) residents worked at the Ankara Numune Teaching Hospital, 31 (31%) at the Ankara Teaching Hospital, and 10 (10%) at the Dr Muhittin Ülker Traffic Teaching Hospital.

The questionnaire consisted of 23 open- and closed-ended questions, asking about general demographic data, place of work, training conditions (like the order of rotation), satisfaction with the duration of rotations, appropriateness of the training, need for new rotations, suggested new rotations, opinion on awareness of clinical teachers about family medicine training specificities and administrative issues. Participants were asked to rate their satisfaction with the duration of the rotation using a three-point Likert scale. The question concerning suggestions for new rotations was open-ended.

Descriptive statistics was used to present the results.

Results

Seventy-one (70%) residents stated that the order of rotations is important and suggested the following rotation order: 1. internal medicine (n = 77, 76%); 2. pediatrics (n = 77, 76%); 3. gynecology and obstetrics (n = 50, 49%); 4. general surgery (n = 49, 48%); and fifth, psychiatry (n = 69, 68%).

Responses concerning satisfaction with the duration of rotations showed that 66 (65%) residents were satisfied with the duration of internal medicine rotation. Twenty-seven (27%) considered it to be too short. and 8 (8%) thought that it lasted too long. Sixty-seven (66%) were satisfied with the duration of rotation in pediatrics. Nineteen (19%) found it to be too short, and 15 (15%) to be too long. Fifty-two (52%) residents were satisfied with the duration of gynecology and obstetrics, whereas 34 (34%) found this rotation to be too long. Forty-nine (49%) stated that the duration of general surgery rotation is adequate, and 38 (38%) thought that it should last as long as necessary. Sixty-nine (70%) residents were satisfied with the duration of psychiatry rotation, and 21 (21%) thought that it could last longer.

Eighty-three (82%) residents stated that basic skills for family practice were not sufficiently covered by the 5 mandatory rotations and suggested further rotations and change in duration of the rotations (Table 1).

Fifty-six (55%) residents stated that training in teaching hospitals was not sufficient for family medicine practice. Seventy-five (74%) residents did not think that their clinical teachers at teaching hospitals

Table 1. New rotations and rotation durations suggested by the family medicine residents in Turkey

Rotations suggested	No. (%) of residents who suggested the rotation	Suggested duration of rotation (months)
General practice	86 (85)	6
Otolaryngology	71 (70)	2
Dermatology	64 (63)	1
Orthopedics	41 (41)	2
Rehabilitation	29 (29)	2
Public health	28 (28)	1
Neurology	24 (24)	1
Urology	7 (7)	1
Other (ophthalmology, infective diseases, sports medicine, etc.)	19 (19)	

were aware of the concepts and training needs of family medicine residents. Ninety-nine (99%) respondents wanted a coordinating department for postgraduate program in family medicine to be established at their teaching hospitals. Ninety-nine (99%) residents stated that the clinical teachers at teaching hospitals should receive training on the concepts of family medicine.

Discussion

The current curriculum for family medicine postgraduate training aims to produce graduates who are proficient in the management of common health problems and who can provide timely emergency surgical and obstetric interventions. In reality, there is a common dissatisfaction with the training in family medicine, implicating that residency programs should be modified and opinions of the trainees about what skills are most important in family practice taken into account (7). Most residents surveyed in our study stated that rotations in internal medicine and pediatrics should be the first. Higher involvement in training in these two areas and the fact that the content of training is closer and more relevant to family medicine could be the reasons for such finding (8). Enhancing basic medical knowledge and skills in these two fields might help residents during their further training in rotations that include more surgical skills, such as general surgery and gynecology and obstetrics.

The duration of rotations in internal medicine and pediatrics was perceived as sufficient. Although the majority stated that the duration of rotations in gynecology and obstetrics, general surgery, and psychiatry were sufficient, a significant percentage of residents responded that these rotations were too long. The reason might be lesser involvement of the residents in these clinical fields. During gynecology and obstetrics rotation, residents are expected to work more at the departments of antenatal care and family planning and general surgery than in emergency departments. The lack of opportunity to work in outpatient settings, unavailability of family practice in primary care setting, and insufficient training in medical fields not covered by the postgraduate program are the major reasons for dissatisfaction of family medicine residents (5). Basic principles of family medicine, such as continuity of care and comprehensive approach, cannot be addressed through such a formal, hospital-based curriculum (2).

Residents suggested additional rotations that would be more relevant to primary care. The most desired one was a rotation in a primary health care setting, followed by otorhinolaryngology, dermatology, and orthopedics, as found in another study (9). This is hardly surprising because family physicians are expected to be broadly trained as comprehensive caregivers who are the first to deal with common and diverse health problems of the population. Furthermore, it was suggested that family physicians should be actively included in health promotion and disease prevention and able to provide continuous care of a broad spectrum of acute and chronic problems commonly encountered in family practice (2). All this should be taken into account when revising the curriculum for family medicine training.

More than a half of the respondents were dissatisfied with family medicine training in teaching hospitals. Several factors may contribute to this dissatisfaction. First, training takes place only in teaching hospitals, whereas family physicians are mostly expected to work in outpatient settings. Residents can become efficient family physicians only when trained in family practice setting (10). Second, almost all postgraduate training in family medicine takes place in teaching hospitals not fully integrated into the primary health care system. Residents are taught to deliver health care in a system different from primary care and to deal with patients only during their stay at the hospital and not over longer period, as family physicians do (11).

The importance of role models and mentors in medical education is well known. As family medicine training moves to outpatient settings and involves more community-based faculty, there is a growing need for educational programs aimed at the teaching faculty themselves, to help them develop skills necessary for effective and efficient teaching (5). The Ministry of Health needs to be made aware of the need for competent and high-quality teaching staff in teaching hospitals. Establishing coordination centers for family medicine training will help residents in their further training and career development. These centers could also initiate faculty development programs, where topics like teaching in family medicine, team leading, system theory, process of work, and statistics would be addressed. All this could contribute to increasing satisfaction of family medicine residents with their postgraduate education.

In conclusion, before the specialists in family medicine make significant contribution to the primary health care system, the Turkish Ministry of Health has to improve the current curriculum of postgraduate training in family medicine by taking into account opinions of family medicine residents and the Turkish Association of Family Physician. Adequate postgraduate program in family medicine would eliminate residents' dissatisfaction and enhance the production of efficient and competent family medicine specialists. Also, this approach could be the best way to overcome existing problems, ie, a mismatch between the training and practice, lack of appropriate infrastructure, and financial and organizational problems in family medicine in Turkey and other countries with similar system of education and socioeconomic settings.

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