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AN OVERVIEW OF FAMILY MEDICINE SERVICES IN THE WORLD AND IN TÜRKİYE[3]

Hakan AKAYDIN[1], Alişan BALTACI[2*]
[1]Yüksek İhtisas Üniversitesi, Sağlık Hizmetleri Meslek Yüksekokulu, Ankara, Türkiye
hakan.akaydin@gmail.com (https://orcid.org/0000-0002-3280-405X)
[2]Yüksek İhtisas Üniversitesi, Sağlık Hizmetleri Meslek Yüksekokulu, Ankara, Türkiye
armada.alisan@gmail.com (https://orcid.org/0000-0002-0109-389X)
[3]Bu çalışma, birinci yazarın ikinci yazar danışmanlığında tamamlamış olduğu yüksek lisans tezinden türetilmiştir.

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*Corresponding author

Abstract
Family medicine emerges as the most influential factor of primary health care services in terms of being easily and quickly accessible by all individuals and being free of charge. Therefore, family medicine is critical, especially in health promotion and protection functions. Today, it is known that individuals' lifestyles seriously affect health, and many chronic health problems can be prevented by changes made in lifestyle. It is seen that all of the countries that have achieved long-term success in the health system use primary health care services effectively and efficiently. However, especially family medicine services are critically important for the effective and efficient use of primary health care services. In this context, family medicine, as a primary health care service, facilitates the effective use of health services, reducing the burden on secondary and tertiary care, thus contributing to the more efficient use of general health services. This study shares the general situation in Turkey and the world regarding the family medicine institution, one of the healthcare providers' most frequently consulted structures.
Keywords: Family medicine, primary healthcare, service, Türkiye

1. Introduction

Today, the sustainable success of health systems is possible primarily through the effective and efficient use of primary health care services. Therefore, especially family medicine services are of critical importance for the effective use of primary health care services.

Among the main features of family physicians is that they provide comprehensive and easily accessible health services to individuals in coordination with their families and the environment they live in. With this aspect, family physicians provide the closest and most continuous health service to the people. They are the most effective health workers in the essential functions of primary care, especially in terms of protection and health development. On the other hand, it is known that lifestyle directly affects the health of individuals, and they can be protected from many chronic diseases with some positive lifestyle changes. As a health service that individuals can access quickly and easily, family medicine significantly impacts the protection and development of people's health and lifestyle.

In this context, family medicine, as a primary health care service, mediates the effective use of health services, thereby reducing the burden on secondary and tertiary care, thus contributing to the more efficient use of general health services.

This study shares the general state of family medicine, one of the most frequently applied structures among healthcare providers in Turkey and the world.

2. LITERATURE REVIEW

2.1. The Concept and Definition of Family Medicine

Family physicians are responsible for *"providing comprehensive and continuous personal preventive health services and primary diagnosis, treatment, and rehabilitative health services to each person, regardless of age, gender, and disease"* (Agadayi et al., 2021), and who provide mobile health services to the extent necessary and work on a full-time basis. They are family medicine specialists or specialist physicians or physicians who received the training stipulated by the Ministry (General Directorate of Public Health, 2022).

Family medicine is a specialty and a discipline that is at the forefront of the health system, is trained to take the first step towards providing care for any health problem, requires a particular set of knowledge and skills, and where the physician-patient relationship is essential (Olesen et al., 2000, p.355). However, previous definitions have yet to be entirely satisfactory, as it is generally difficult to understand and define the principles of family medicine or the desirable characteristics of a general practitioner. In this sense, family medicine, where communication is a critical factor, focuses on promoting and developing primary health care, creating sound public health, and meeting the needs of society in the field of health (Hashim, 2017).

The knowledge created by the developments in the technology field has led to the formation of specialization areas in medicine. The focus shifting from curing the human to curing disease made it difficult for undifferentiated people to access appropriate health care. It brought primary care, general practice, and family medicine to the agenda after the Second World War (Akdeniz et al., 2016, p.29). Considering that *"health is one of the primary elements of development in social life, the primary goal in advanced health systems is to ensure that everyone can access health services at the rate they need, and thus to increase the living standard and health quality of individuals"* (Yalman et al., 2015, p.25).

International research shows that health systems with well-trained family physicians and family health personnel, which include many structural elements, provide more effective health services than economically and clinically passive ones (Baser et al., 2015, p.26). Family health personnel, who are members of the family medicine system, are midwives, nurses, health officers, and emergency medical technicians who act together with the family physician and are contracted or assigned by the *"Ministry of Health"* (Artantaş et al., 2012, p.81).

The importance of good primary care is now well known. Starting from the *"Alma-Ata Conference"*, with many declarations such as the *"Ljubljana Charter"*, the *"World Health Organization"* has drawn attention to primary health care services and family medicine, as well as specialty and hospital care to a large extent, with its *"Health for All"* discourse (Jack et al., 1997). In primary healthcare institutions, health services that are considered preventive and curative health services are offered together, and *"people can access all these services by applying to their family physician"* (Samancı, 2021). In this context, epidemiological studies also show the importance of early diagnosis for treating diseases in the long term. Furthermore, family medicine is a discipline designed to

prevent potentially harmful situations due to its unique role in caring for patients throughout their entire lifespan. Therefore, family physicians are in the best position to incorporate knowledge into clinical practice regarding the positive effects of early detection on long-term health (Crump, 2015).

Patients are in contact with their family physicians even if they do not have a health problem. In addition, family physicians are the first meeting point with the patient. The most important feature that makes family medicine services different from other branches of medicine is that they progress with a continuous system and are easily accessible to individuals in need (Ak, 2010, p.404). The best examples of being in contact with family medicine even when there is no health problem are the health reports of driver candidates, which are requested more frequently, premarital health reports, and reports that can take legal action (Vural & Yaman, 2016, p.43). Therefore, family medicine is a health service offered to all individuals, not only in case of illness but also to protect and improve health, without making any demographic distinctions such as gender or age (Ateş, 2011, p.12 cited in Kaya et al., 2020, p.413).

"Family medicine has matured as an academic and scientific discipline with its basic concepts, knowledge, skills, and research areas, including medical, psychological, social, and behavioral sciences, patient-centered care, and health services in examining common diseases" (Lam, 2004). It is also considered that family medicine is more than a mix of knowledge gained from various skills and specialties required for comprehensive and continuing medical care, such as medical counseling, outpatient care, and preventive medicine, and it is a separate discipline (Baker, 1974). On the other hand, some research results show that individuals find the scope of family medicine narrow and do not apply to the family physician first in case of a health problem, and generally prefer family medicine to prescribe medication (Baş, 2017).

Clinicians who teach in the field of family medicine have emphasized the importance of primary care specialization and family medicine, as the latest generation of medicine, reaching all geographical locations and all types of populations to provide comprehensive health services (Stange et al., 2001, p.289). Therefore, the person is the focus of attention for the family physician. However, for the family physician to do this correctly, he or she should know not only what health problems exist but also their incidence and prevalence (Turabian et al., 2016, p.1).

In this context, family medicine is crucial in detecting negative situations in the health field while providing the most suitable environment for detecting new cases and examining diseases and processes (Regnaut et al., 2015). Thus, family medicine, along with other components, has the transformative power and integrating potential to meet ever-changing human and community needs and improve the entire nation's health (Kahn, 2004).

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2.2. Features of Family Medicine

According to generally accepted research, family medicine consists of four main subjects:

1. Clinical medicine: The problems faced by most family physicians are clinical problems, and most of the decisions they make are clinical decisions, and a solid understanding of medical knowledge and clinical methods are needed.

2. Epidemiology: Distribution, prevalence, incidence of the problem, and the markers affecting them are essential in preventing and recognizing the disease-producing condition.

3. Human behavior: Family medicine requires understanding the patient's physical, emotional, and social dimensions. That needs a behavioral style integrated with insight, communication skills, and clinical intelligence. Understanding the sociocultural characteristics of a patient and knowing the social class and family structure can affect the background, types, and triggers of his disease.

4. Human development: Knowing how people respond to crises, sudden changes, and situations can result from a failure to adapt and how health can deteriorate, and the ongoing relationship with patients informs. These situations, possible deviations, normal development processes, and stages should be followed (MacWhiney, 1969).

According to the *"World Health Organization"*, family medicine's seven characteristic features are *"being general, continuous, comprehensive, coordinated, collaborative, family-oriented care, and community-oriented"* (Çakır, 2015, p.115).

Family medicine is person-centered, not disease-focused. That is, the rationale of the discipline is based on the health of people and populations, not the enumeration, diagnosis, and management of individual diseases. That contrasts with the academic field, where health is considered the absence of disease and disease as the sum of individual health problems (Starfield, 2009).

Role conflict arising from creating a new specialty can inevitably create tensions with existing cadres, especially when there is potential overlap between family medicine and public health specialties and internal medicine, especially with their respective roles (Moosa et al., 2013, p.213). In this context, the duties of family physicians have been made globally similar thanks to the efforts made globally and the effort to define the principles and practices related to family medicine as a standard (De Maeseneer et al., 2008).

The industrialization of medicine has further weakened the personal relationships and communication between patients and physicians. Studies conducted today show that patients are increasingly accessing health-related information from websites. In this context, family medicine has become remarkable in terms of reducing the physician shortage, regulating the distribution of physicians according to geographical and specialty areas, health care at the individual and family level, controlling costs, primary care, patient education, and preventive medicine, and improvements to be made in this area (Stephens, 1989, p.108). In addition, it is known that primary health care services are necessary for efficient and effective health services for both developed and developing countries in

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terms of resources (Beasley et al., 2007, p.518). In this context, it is evaluated that a well-founded primary healthcare service should be provided to fully respond to the health needs of society under the principles of equity and to control costs (Akman, 2014, p.70).

Birth is a fundamental event for the formation of the family, and family physicians play an important role in maternal, infant, and child health in many areas (Cohen et al., 2003). A study concluded that 93% agreed that mother-child health and care education in family medicine should be compulsory (Rodney et al., 2006). Maternal and child health education is vital in family medicine specialization (Coonrod et al., 2011, p.631).

The importance of family medicine for the success of a sustainable health system and the necessity of training a qualified physician in primary care is known by all those interested in public health (Ünalan et al., 2017, p.24). Family medicine is part of the process of adjusting medicine itself to the changing needs of society. The common point of family physicians consists of personal and social relationships rather than technical aspects of medicine. At this point, their commitment is to a group of people rather than a body of knowledge, and the educational environment and the role of educators are of great importance in the training of family physicians (MacWhinney, 1975).

Family medicine services are even more critical in rural areas because general practitioners primarily provide medical care in rural areas. In addition, it is known that the rural population lives in relatively more unfavorable living conditions than the cities. However, it is also evaluated that the data on the type and prevalence of health disorders in relatively rural areas must be clarified (Probst et al., 2006).

On the other hand, it is known that family medicine is of critical importance in protecting individuals from diseases, improving their health, preventing the progression of the disease by applying early diagnosis and treatment methods in case of disease, directing individuals to higher levels in the field of health and providing health services when necessary. However, it is considered a significant opportunity in the general health system since the procedures and practices in primary health care services cost much less than therapeutic health services. Those who receive this service do not have to pay money (Baş, 2017, p.45).

Students who receive training in this field may hear some complaints from family physicians about the lack of physicians, excessive workload, decreased financial income compared to different specialties, and difficulty in surviving (Rosser & Kasperski, 1999). Therefore, it is considered that the low attractiveness of family medicine will negatively affect the delivery of primary health care services in the future, and it is recommended to make family medicine more active with attractive health policy strategies and factors such as wages and promotions to prevent this situation (Seifert et al., 2009). Furthermore, since family medicine also affects the roles and functioning of other professions in the rapidly changing health environment, it would be appropriate to fight for a more apparent identity and improve conditions in this critical issue to restructure the health system (Beaulieu, 2008).

In this context, two different aspects emerge in general for the development of family medicine. The first is to preserve family medicine's traditional functions while adapting to changing and developing conditions. The other

is to focus on areas of specialization and train specialist general practitioners due to the value attributed to specialization by society and the professional system as an alternative response to rapidly developing practices and scopes (Beaulieu et al., 2008).

2.3. Duties of the Family Physician

Family medicine, which brings new applications to health services offered in primary care, has brought a different working style, additional obligations, and job descriptions to health professionals and family physicians in this system (Korukoğlu et al., 2014, cited in Yardımcı et al., 2016, p.82).

In general, family medicine has basic principles such as accessibility, continuity, comprehensiveness, and coordination, and its duties can be listed as follows:

1. Data Collection and Record Keeping,
2. Preventive Medicine,
3. Health Education,
4. Health Counseling and Guidance,
5. Diagnosis and Treatment Services in Primary Care,
6. Monitoring of Chronic Diseases, Rehabilitation, and Health of the Elderly,
7. Periodic Inspection (Dikici et al., 2007).

2.4. Overview of Family Medicine in the World

In all countries, the position and practice of family medicine and general medicine are regulated and implemented by law. Therefore, no standard and uniform family medicine strategy is valid in every country and discipline (Oleszczyk et al., 2012).

In this sense, family medicine is a science and an art with this aspect. It is evaluated that the development and knowledge of this art can contribute to acquiring scientific research. On the other hand, family medicine is a branch of clinical science with scientific and technological components such as medicine and clinical medicine (MacWhitney, 1978, p. 55).

Notably, the number of medical students choosing family medicine as a career has decreased recently (Wright et al., 2004). That has led to reconsidering what is known about the factors affecting the choice of specialty. For example, *"while gender, age, marital status, and ethnicity are weakly associated with the choice of specialty, those who believe that primary care is essential, do not have high financial expectations, and do not plan a research career are more likely to prefer family medicine"* (Senf et al., 2004).

On the other hand, generating new knowledge through research is a feature of medical specialties. However, it is stated that scientific research in family medicine had a low priority when it was first established (Gotler, 2019, p.70). As a result, primary healthcare services had to struggle for recognition in the academic field (Haggerty,

1991). As in most specialties, research in family medicine has not progressed rapidly. Despite this, family medicine pioneered most medical education innovations (Roosser, 1987, p.1419).

Although the position of family medicine has improved significantly in academic terms and more importance has been given to primary care and current services as a result of rapid political changes, it can be said that it still has not reached the required standards (Kochen & Himmel, 2000). It is also considered that family physicians need more time and more sustainable mentoring in order to increase their academic studies and conduct research in a comparable number and content with alternative education programs (Curtis et al., 2003).

At the beginning of the medical discipline, the main focus was on diseases, with the effect of treating the disease instead of the patient. In 1923, with Doctor Francis Peabody, it was argued that this situation divided the health systems and left the patients insoluble. Instead, it was necessary to focus on personal service delivery and move to general practice, which evaluates the individual as a whole (Aktaş & Çakır, 2012, p.22). *"By the twentieth century, the relationship between the patient and the physician has evolved into the relationship between the disease and the physician. Thus, patients began to be examined in smaller pieces day by day. This situation has emerged as an inevitable result of increased knowledge in medicine. It has caused patients to be separated according to their treatment type (surgery-internal medicine), than age (pediatrics-geriatrics), gender (gynecology), and organs (nephrology, cardiology, etc.) that the diseases affect"* (Özkaya, 2016).

Family medicine is accepted as a specialty in all countries. However, practices may differ between countries, and the duties of family medicine may be different everywhere in the world. For example, in the United States, family physicians are reported to make more patient visits each year than any other specialist outside of three or four limited specialties (Starfield et al., 2005). As a result of the changes in Central and Eastern Europe at the end of the twentieth century, some countries became members of the European Union. In contrast, others had to struggle with economic and political instability. In this process, there have been extensive changes in every field, especially in the primary healthcare system in Europe. It aims to move towards common standards in health service delivery (Oleszczyk et al., 2012). Therefore, family physicians may have different duties and authorities in different parts of the world. For example, they can be called to perform major surgeries in rural Austria, attend births in Canada, care for hospital patients in the United States and the Netherlands, and supervise public health functions in Cuba. However, family physicians have two typical duties globally. These are the ongoing treatment relationship with their patients, expressed as continuity and service provision to anyone with a health-related need, which can be expressed as comprehensiveness (Roberts et al., 2011. p.84).

Countries such as England, Denmark, and the Netherlands are the first to implement the practice of patients accessing a specialist physician with a referral letter issued by their family physician (De Maeseneer, 2017. p.19). In Spain, it is generally considered that family medicine education is not sufficient in medical education. The curriculum in family medicine, which is usually optional, is based on hospital education and is taught through clinical internships. Usually, little emphasis is placed on preventive services, physician-patient communication, teamwork, or community activities (Rabadan, 2010, p.35). Considering these conditions, the tendency of both students and the academic community to not evaluate family medicine as it deserves is not surprising.

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Unfortunately, the current structure only encourages a few medical faculties to consider family medicine as a career choice (Sakurai et al., 2003). Students who choose family medicine as a career in medical school consist of those who come from rural areas, want to work in a rural or disadvantaged region, are less wealthy, or prefer clinical practice to research (Senf et al., 2003). In this context, it is considered that the focus of family medicine should be to develop the research culture and increase its capacity (Bolon & Phillips, 2010, p.486).

According to the *"Future of Family Medicine Project Leadership Committee"* (2004), it is unanimous that it is right to act according to the following rules, from a failed system to a new system that can guide the redesign of health services:

Safe aimed at helping and preventing injury to patients in care.

1. "*Effective—providing scientific-based services.*
2. *Patient-centered—providing respectful care sensitive to individual patient preferences and giving importance to the patient's needs and values to guide all clinical decisions.*
3. *On-time—reducing waits.*
4. *Efficient — avoiding waste of equipment, supplies, ideas, and energy,*
5. *Fair—providing care that does not vary in quality due to personal characteristics such as gender, race, ethnicity, geographic location, and socio-economic status"* (Kahn, 2004).

In Middle Eastern countries, the state is the primary provider of health services, and health insurance is a public responsibility. Therefore, for Middle Eastern countries, family medicine training in most programs occurs mainly in hospitals. However, after graduation, it is considered that there is a need for better opportunities for creating and continuing research activities in family medicine and for professional development, and this field should be developed (Abyad et al., 2007). Some of the changes detected in recent studies worldwide are that family physicians are not interested in providing home care, do not make house calls for patients, and do not offer home visits as part of their medical education. In this context, family medicine is also changing over time, and it is seen that what was once done by family physicians is now done by emergency room physicians, hospitals, physicians from other branches, and even palliative care physicians (Ladouceur, 2015, p.102).

"The challenges facing family medicine are exacerbated in developing countries where limited funding for health care is often inadequate" (De Maeseneer et al., 2008). *"In the 1950s, the American humanist psychologist Carl R. Rogers developed the concept of client-centered treatment"* (Rogers, 1946). This approach was introduced and promoted in the medical field as *"patient-centered medicine"* (Balint, 1970). *"Today, patient-centered care has been associated with positive outcomes such as reduction of malpractice, patient satisfaction, decreased complaints, consultation time efficiency, positive patients' emotional state, and medication compliance"* (WHO, 2010).

Another issue pointing to the importance of family medicine and primary health care services is the guiding features of the studies on this subject. For example, while the factors affecting the prevention of common diseases are systematically examined, family medicine is one of the specialties that are evaluated more (Maugans &

Wadland, 1991). In addition, it is evaluated that qualitative interviews with primary health care services will help to improve the process in order to understand better the variables that are most meaningful for patients with the conceptual model and their impact on long-term outcomes and to analyze which dimensions of patient-centeredness exist (Hudak et al., 2013).

2.5. Family Medicine in Turkey

Family medicine, which was first considered a sub-branch of health center medicine and not a separate specialty, came to the fore in Turkey for the first time in the 1970s, simultaneously with the world. Then, in 1983, family medicine became a field of specialization by being included in the Regulation on Specialization in Medicine (Algın et al., 2004, p.252). With *"Law No. 224 on the Socialization of Health Services"* that entered into force in 1961, the Health Center system was first started in Turkey in the province of Muş in 1963 and spread throughout the country with the participation of Manisa in 1984 (Ministry of Health, 2015). Despite Turkey's early planned primary healthcare activities, the *"Ministry of Health"* did not accept family medicine as a medical specialty until 1984. In 1993, the Council of Higher Education started to establish family medicine departments in universities (Ünlüoğlu & Ayrancı, 2003), and family medicine specialists have been training in Turkey since 1985 (Aydın, 2007). However, family medicine has become a separate discipline by being included in the medical specialty statute in 1983. Therefore, it is said that the legal regulation on family medicine clinical practice training in family health centers should be re-examined (Uğurlu & Üstün, 2018, p.123). The number of family medicine units in 2020 is 26,594, and 42.2% of the applications to physicians were made to institutions providing primary health care services, while 57.8% were made to secondary and tertiary health institutions. While the number of applications to a physician per person was 9.8 in 2019, it decreased by 26.5% and became 7.2 (TUIK, 2019). According to the Presidential Annual Program for 2022, the number of units will be increased to 30,680 by the end of 2022 by improving the quality and quantity of health services provided by family physicians. As a result, the population per family physician will be reduced to 2,800 people (Strategy and Budget Presidency, 2021).

With the *"Law on Family Medicine Pilot Implementation"* enacted in 2004, Family Medicine practice started in Düzce. It started to be implemented nationwide at the end of 2010 (Ministry of Health, 2004). According to the Family Medicine Practice Regulation (2004), *"the basis of the model in family medicine is the family medicine unit, which consists of a family physician and family health personnel. Everyone living in the country chooses a family physician, and each individual in the family can choose a different physician. A minimum of 1000 and a maximum of 4000 people can register with a family physician. Family physicians may serve individually in a separate building or flat, or several family physicians may serve together under the same roof. This unit is called a family health center when they work under one roof. In this model, the family physician is usually a general practitioner or a specialist physician who works as a general practitioner. This specialist may also be a family medicine specialist. Family physicians are responsible for primary care. It provides service only to people registered in their list"* (Family Medicine Practice Regulation, 2014).

The health sector is becoming an area that provides higher service standards and focuses on the customer (Baltacı, 2018, p.47). As a result of demographic data and changes in living conditions, many changes are needed in health

systems in the form of size, scope, content, and organizational design (Nur et al., 2009, p.13). As a result, it aimed to improve the current system to solve problems in the delivery of health services in Turkey. Therefore, a new model was created instead of the current system under health transformation (Öztek, 2006). In this context, family medicine in Turkey is planned not only as a model but also as a holistic system with factors such as human resources, organization, financing, improvement in physical conditions, and infrastructure of the legal framework (Vural & Özkahraman, 2006, p.176). Community focus, accepted as one of the essential competencies of family medicine, requires teamwork. Meeting on common ground with health professionals and people and organizations outside the sector is essential to achieve this. Therefore, it is considered that it is crucial to meet the need at this point during the family medicine specialization (Dağcıoğlu & Üstün, 2017, p.300). Family physicians take the individuals registered in their region holistically and offer preventive, health-promoting, and curative health services as a team with family health personnel (Eğici et al., 2012, p.126).

During the delivery of health services, it is essential to develop solutions that are compatible with the needs and wishes of patients and healthcare providers. For example, while the person must go to the hospital personally to receive health services, the opposite can be applied in family medicine. The young people in the family can do the procedures for older ones, such as prescribing drugs, without the need to go to the family physician physically since the physician knows the patient (Delican et al., 2019). In this context, it is evaluated that *"an application similar to the family medicine model applied in Turkey will replace the free family medicine model applied in France. This model was implemented in some pilot provinces and received a positive response. For this practice to be an effective solution, the number of physicians should be kept high enough, and the time allocated to the patient should continue to be protected in this way"* (Çeçem et al., 2015, p.158).

Turkey's health services policies are generally based on understanding the social state. In this context, primary health care services were organized according to the population, and preventive and curative health services were provided together in health centers by family physicians and medical personnel (Balcı & Erol, 2014, p.247).

Family medicine after multidisciplinary clinical rotations consisting of one of the branches of Internal Medicine, Pediatrics and Gynecology, Gynecology and Mental Health and Diseases, Cardiology, Chest Diseases, Emergency Medicine, Skin and Venereal Diseases, and optionally Neurology / Physical Medicine and Rehabilitation / General Surgery specialist title. The quality of family medicine has increased thanks to the courses in family medicine, basic principles of clinical medicine, medical interviews, triage, examination, physical examination, and communication skills in medical faculties (Ersoy & Sarp, 1998).

Considering the accessibility, speed, and the fact that patients can apply to the family physician more quickly and easily, it is possible to consider that family medicine services are more favorable than health centers (Çevik, 2013, p.2). According to a study conducted with physicians who worked in both the health center and family medicine, family medicine was evaluated more positively than health centers in showing more attention to patients, being followed by a single physician, and keeping records in the computer environment. Health centers, on the other hand, were evaluated as better than family medicine in terms of community-oriented practices, teamwork, home visits, population planning, environmental health practices, and filiation practices (Çevik & Kılıç, 2013, p.122).

On the other hand, while there are health officers, nurses, midwives, medical secretaries, and driver positions among the staff in the health center, apart from the physician, the family medicine practice is predominantly based on the physician, as the name suggests (Kasapoğlu, 2016, p.148). In this context, all these changes made in practice have affected the health personnel and the results in the health field both positively and negatively. For example, while the wages of family physicians have increased, their workload has also increased in direct proportion. Furthermore, although not all records can be made reliable and complete, an electronic record system has been developed. As a result, contracted work was initiated, the occupational safety of the family physician was relatively reduced, and the working hours were extended (Çevik, 2013, p.3).

Receiving service from a different physician each time he goes to the hospital may result in the inability to analyze the patient correctly in secondary and tertiary health care services. In addition, the lack of counseling services, especially for chronic diseases, may cause unnecessary repetitive interviews. In this context, it is considered that the referral chain to be created by strengthening family medicine will take the workload of secondary and tertiary health care (Üstü & Uğurlu, 2015, p.247).

2.6. Legal Rights of the Family Physician

Regulations are frequently made regarding the scope and legal legislation of the primary care and family medicine system. This situation causes some problems to be experienced even at the points where the application has been switched to long ago, and the system is expected to run smoothly. Therefore, the system should be considered holistically.

The rights of the family physician include the principles of not harming the patient, being helpful, keeping the patient's secrets, non-discrimination, respect for the sanctity of human life, protecting professional dignity, sharing information among colleagues and solidarity and necessitating an atmosphere of medical knowledge-skills, communication, social and moral values. On the other hand, a physician-patient relationship is a form of relationship in which only the duties and responsibilities of physicians are defined (Türkmen, 2014). In this context, the concept of patient rights has been mentioned frequently in recent years, and the physician's rights in the patient-physician relationship are put on the back burner. On the other hand, some rules must be followed to communicate effectively with each other, and these rules are also fundamental to the patient's participation in the decision-making process (Tanriverdi et al., 2014, p.21).

In regions where family medicine is practiced, people have to register with a family physician and have the right to choose the family physician they want (Law No. 5510, 2006). Being able to choose a physician is based on the fact that there is a stable relationship between the patient and the physician and that this is mutually maintained within the framework of the patient and physician's demands. Although the right of the individual to choose his physician is essential in providing quality health service delivery and patient satisfaction, it has been reported that most individuals continue to receive service from the family physician determined by the administration at first. Therefore, most of them do not use their right to choose a physician (Çetinkaya et al., 2013, p.54).

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A quality physician-patient relationship can only be maintained in an environment where there are patients whose rights are provided and protected and healthcare professionals who respect these rights. Therefore, it would be more appropriate to state that physicians' and patients' rights are consistent. On the contrary, they intersect and should be evaluated together (Karagülle, 2000). In this context, it is considered that the physician-patient relationship should be re-evaluated based on the priority of rights and mutual participation of both parties (Arda, 1998, p.121).

2.7. Organization and Referral Chain in Family Medicine in Turkey

In the stratified health service delivery practiced in Turkey, there are non-governmental organizations and the public and private sectors. However, at the primary level, it consists of family medicine and mother-child health centers as the first step in the public sector, public hospitals at the secondary level, and university hospitals at the tertiary level (İlhan et al., 2006 cited in Baltacı, 2020, p.21). In this context, applying the referral chain in the family medicine system, which is currently maintained with differences in most developed countries, is at the top of the starting point and an indispensable element of the system (Bektemür et al., 2018, p.258).

In the family medicine system, it can be faster to direct patients to the appropriate hospital and specialist with a correct referral chain for sustainable success. Thus, health services will be used more effectively and efficiently, cost control will be ensured, and patients will be prevented from being victimized without intensifying secondary and tertiary care with higher costs (Aydın, 2004, cited by Atadağ et al., 2016, p.142).

The first of the two types of referral chain application is the model in which the family physician has authority and control over other service steps, and there is a compulsory referral chain except for emergencies. Second, it is an open system application where individuals can reach the family physician and the specialist without complying with the referral chain. Although there is a referral system in practice in Turkey (Official Gazette, 2006), an open system (parallel) system is applied due to an insufficient number of family physicians in the transition period (Sosyal et al., 2016, p.84). In this context, the factors that hinder the implementation of the referral chain can be counted as reducing the population of family physicians by increasing the number of family physicians, improving the technical and physical facilities of Family Health Centers, and bringing them to a standardized structure. In addition, increasing people's health literacy level regarding public health activities will positively affect the process (Bulut & Uğurluoğlu, 2018, p.119). In addition, the first application must be made to primary care and family medicine to implement an effective referral chain in the system (Macintyre et al., 2003). In addition, individuals know they will contribute when they apply directly to a specialist in other health institutions before the family physician.

The inability to find solutions to health problems and the thought that better quality service is provided in hospitals can be counted among the reasons family medicine is not preferred. In addition, it is considered that the inadequacy of family health centers in terms of special equipment and insufficient trust in family physicians affect this decision of individuals. In this context, it is stated that improving technical and physical conditions in family medicine and studies to increase confidence will be appropriate (Güven & Aycan, 2018, p.25).

For example, in the UK, the report written by the specialist physician in the hospital is forwarded to the patient's family physician. This way, the physician can follow the patient's condition and observe whether his directions are in place (Royal College of General Practitioner, 2011, cited in Bankur, 2017, p.68).

It is thought that a health service provided in secondary and tertiary care can also be provided in primary care will increase the expenses in these steps due to the high cost of curative health services, which is not sustainable (Üstü et al., 2011). However, a significant decrease can be observed in hospitals' outpatient clinics, hospitalization, and medication expenses with a correctly applied referral chain. Studies conducted in countries that previously used family medicine practice and referral systems stated that total health expenditures decreased between 8% and 80% (Etter & Perneger, 1998; Holdsworth et al., 2006).

On the other hand, when the referral system cannot be implemented, patients go to the specialist physician with their own decisions. This situation increases the workload of specialist physicians unnecessarily. Therefore, negative consequences may arise, such as the disadvantaged, who need a specialist and cannot benefit from them (Rasoulynejad, 2004). Furthermore, it is known that when the referral chain application is not implemented correctly, inefficient, unnecessary, and ineffective secondary and tertiary healthcare services will be concentrated (Macinko et al., 2003).

2.8. The Importance of Physical Conditions in Family Medicine

In Turkey, campuses already provide comprehensive health services, including shopping opportunities and hotel management elements. However, there are very limited physical conditions in family medicine and other primary healthcare services (Cerrahoğlu, 2016, p.83). The main organizational factors that affect job satisfaction are the characteristics of the job, managerial and supervisory factors, income level, promotion and training opportunities, other personnel with whom they work, the social and organizational atmosphere of the place of work, socialization opportunities, the personality traits of the employee and the desire for appreciation and the physical conditions of the place of work (Aksu et al., 2002, p.272).

The heat and thermal comfort conditions in the work environment are among the primary factors that positively or negatively affect the performance and job satisfaction of the person (Sevimli & İşcan, 2005). Therefore, the physical and social conditions of the workplace, the working environment, the hygiene conditions, and the adequacy of the technical equipment seriously affect performance. Therefore, it is evident that an employee who makes an extra effort to work in a workplace that is too small, narrow, or hot or cold than necessary cannot be satisfied with the existing conditions and cannot work efficiently (Topçu, 2009, p.21).

While physicians with higher job satisfaction do not experience stress and burnout syndrome, low medical error rates positively affect the quality and standards of patient care (Tekin et al., 2014, p.136). Therefore, the unsatisfactory physical conditions of the workplace negatively affect job satisfaction, performance, health, and socialization, causing a decrease in productivity (Çan et al., 2006, p.19). In addition, it is considered that all these problems will adversely affect the quality of care in cases where the material used in the family medicine system is

insufficient in terms of quality and number, and preventive services such as health education, home visits, family planning, and counseling services are not provided at an adequate level (Baysal et al., 2013, p.28).

In a study, health personnel working in primary care were asked for their opinions on the current practice. In response, it was stated that the physical conditions of family physicians and family health personnel should be regulated, and the number of health care personnel should be arranged according to the region's patient population. Furthermore, they expressed the opinion that the dark areas and injustices in the legal legislation should be eliminated, the administrative workload of the family physician should be reduced, the compulsory mobile service should be reviewed, and the contracts and taxes should be regulated (Doğan et al., 2012, p.114). Article 5-3 of the institutional contract principles regarding the supervision of the technical and physical conditions of the education family health centers are as follows *"Education family health centers and education family medicine units are subject to the inspections of the Public Health Institution of Turkey (General Directorate of Public Health in its new form) in terms of their work and operations, and physical and technical conditions, excluding educational activities. Suppose it is determined that the deficiency or non-compliance situation continues due to the audits carried out for the third time. In that case, the corporate contract is terminated unilaterally by the Institution"* (Uğurlu & Üstün, 2018, p.125).

In this context, it is known that if the level of satisfaction with the physical conditions of family physicians and family health personnel in the workplace increases, job satisfaction levels, effectiveness, and productivity increase in general (Tözün et al., 2008, p.381).

2.9. Legal Regulations Regarding Family Medicine in Turkey

In Turkey, a cascading system is implemented to provide health services. The *"Ministry of Health"* is a practitioner, especially with the identity of planning and supervising the efficiency of primary healthcare services (Altay, 2007, p.45). In this context, *"The State carries out primary health care services through family physicians within the framework of the Family Medicine Law, the Family Medicine Practice Regulation, and the Family Medicine Payment and Contract Regulation. In this respect, family physicians are public officials who carry out the health service, which is a basic and continuous public service"* (Family Medicine Practice Regulation, 2013).

In demarcating family physicians' rights, duties, and responsibilities, making arrangements with the provisions of special and general laws is necessary. However, in areas that cannot be regulated by private law due to the nature of health services, the *"State Servants Law No. 675"* articles are valid (Şişli, 2014, p.166).

Generally, a public employee can be expressed as an individual who work in public institutions, depending on the public law, and whose profession is this, depending on the nature of the work done. Thus, individuals who do not work with a legal bond in the public sector in the form of contracts or appointments are excluded from the scope of public servants (Çağlayan, 2016). In another definition, it includes public employees, civil servants, and temporary and contracted personnel employed with administrative service contracts, except for those working in various structures of public and those working under private law (Günday, 2013). In this context, specialist physicians and

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family health personnel working in family medicine centers are legally evaluated under the *"Ministry of Health"* and in the status of public servants.

According to the legal regulations in family medicine, contracted family physicians are subject to warning points corresponding to the acts regulated in the Family Medicine Payment and Contract Regulation while performing the health service. *"The warning, as mentioned earlier, points are given to family physicians by the deputy governors by establishing an administrative procedure. If these warning points reach a total of two hundred points in a contract period, they may cause the termination of the contract"* (Doğru, 2016, p.491).

With the *"Law on Family Medicine Pilot Practice"* numbered 5238, enacted in 2004 together with the Health Transformation Program, pilot implementation was first started in Düzce on 15.09.2005. With the application, health facilities and health personnel affiliated with SSK were transferred to the *"Ministry of Health"*, and all health services were gathered under a single umbrella (Kasapoğlu, 2016). Then, the *"Directive on the Establishment and Operation of Community Health Centers in Provinces Where Family Medicine is Piloted"* was published (Ministry of Health, 2005).

The Community Health Centers, established to protect and contribute to the development of public health in their regions, were added to primary healthcare services with family medicine. Community Health Centers were established to provide more effective health services by organizing individual preventive and primary services other than diagnosis, treatment, and rehabilitation under the same structure (Demir et al., 2017, p.73). According to this directive, it is stated that more than one community health center can be established in some districts according to the population, at least one in each district. With the transition to the family medicine system throughout Turkey in 2010, the establishment of *"Family Health Centers"* (ASM) and *"Community Health Centers"* (TSM) was completed. The last update was made in the relevant directive on 03.08.2011. Therefore, one community health center should be established in each district and the city centers not subject to the *"Metropolitan Municipality Law No. 5216"* (Ministry of Health, 2015). On the other hand, the areas of duty, authority, and responsibility of community health centers are unclear. Therefore, it is evaluated that what are the duties, powers, and responsibilities of TSMs, the limits of the supervision authority in the family medicine system, and the limits of the enforcement powers should be determined with more apparent expressions in the legislation (Uğurlu et al., 2012, p.8).

As required in the law *"family medicine must provide comprehensive and continuous personal preventive health services and primary diagnosis, treatment, and rehabilitative health services to everyone, regardless of age, gender, and disease"* (Regulation on Family Medicine Pilot Practice and Family Medicine Practice No. 5258, 2004). It is defined as a family medicine specialist who provides mobile health services to a large extent and works full-time or a specialist physician or physician who receives the training stipulated by the *"Ministry of Health"* (Celbiş & Özdemir, 2011, p.558). As a result of this restructuring, the primary applications of the society were family physicians, where health services other than inpatient treatment services were provided. Community health centers, responsible for preventive health services for society and the environment, are less frequented, so the public's knowledge of the services provided has been more limited (Aycan et al., 2017, p.4).

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Since family medicine as a discipline was not fully known in Turkey, some issues faced by the first experts made it necessary to organize them. As a result, *"Family Physicians Specialization Association"* (AHUD) was established in 1990 and was renamed as *"Turkish Family Physicians Specialization Association"* (TAHUD) in 1998. It has seven branches and 2200 members. In addition, AHUD collaborates and memberships with many global organizations in the field (TAHUD, 2021). "*TAHUD works to ensure the development of family medicine as a medical discipline. Therefore, it organizes scientific events to assist in-service training of residency students and family medicine specialists in continuing medical education. For this purpose, it organizes scientific events named National Family Medicine Congresses and Family Medicine Days alternately every two years. In addition, the Departments of Family Medicine of the University organize national and regional scientific events to contribute and support the in-service training of primary care physicians and family medicine assistants"* (TAHUD, 2021).

With *"Family Medicine Law No. 5258"* and the related regulations, family physicians and family health personnel are employed under the *"Ministry of Health"*. In addition, the family physician is responsible for managing the family health center, supervising the team he works with, providing in-service training, and carrying out some health services maintained by the *"Ministry of Health"*. The income obtained in return for this is accepted as a fee by the *"Income Tax Law No. 193"* (Ceyhan & Gündüz, 2018, p.13).

In this context, family physicians must withhold income tax from their wages to the workers they will employ in cleaning, secretarial, and chauffeuring under *"Income Tax Law No 193"*. On the other hand, since they do not have any income, corporate, or value-added tax obligations, they are not obliged to keep an accounting book per the *"Tax Procedure Law"* (Soner, 2013, p.103).

3. DISCUSSION AND CONCLUSION

Quality service means responding to demands, needs, and expectations at a high level and exceeding expectations (Arlı, 2012, p. 29). In this context, all health institutions, especially family medicine, must efficiently use their resources, such as human resources, equipment, and technological equipment. One of the essential tools they can evaluate to achieve this is the power of people and communication (Bektaş, 2010, p.231).

On the other hand, studies in this field show that organizations that provide a more standardized service are more satisfying for the consumer (Kinard & Capella, 2006, p.359). Therefore, providing healthcare services above a certain standard in family medicine, which shows slight variation, is vital in patient satisfaction, physician-patient communication, and the intention to recommend the service. In this context, personalized service is also critical in family medicine. Therefore, to increase patient satisfaction, instead of a single type of service, it may be recommended to provide local or harmonized services equipped with personal characteristics that can be differentiated according to needs. For example, regular follow-up of the patient known to have a specific chronic disease by the family physician and reminding the test periods can be examples of this personalization.

In this direction, in order to be unique and different in family medicine services, it is essential to base the needs of the patient, to use communication skills at the highest level, to ensure patient satisfaction, and to increase the quality of service (Agriculture, 2010, p.149). Patients who perceive the service provided to be of high quality tend

to seek service in family medicine again when they need a similar health service. Moreover, they intend to recommend this service to others (Dursun & Çerçi, 2004, p.7). It is considered that this will enable more effective and efficient use of resources by reducing the burden on the secondary and tertiary Stages.

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