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# ATTITUDE OF A SAMPLE OF GENERAL PHYSICIANS WORKING IN SOME PRIMARY HEALTH CARE CENTERS IN BAGHDAD, AL-KARKH TOWARDS FAMILY MEDICINE

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ABSTRACT:

Worldwide, there is a general agreement that primary care is the linchpin of effective health care delivery, family medicine as a cornerstone in the modern health system would be the best to achieve a more efficient and effective health care delivery. The aim of this study was to explore the attitude of a sample of general physicians working in some primary health care centers in Baghdad towards family medicine. A cross- sectional study was implemented by collected, data using filling the questionnaire by general physicians. A convenient sample including 200 general physicians working in twenty selected primary health care centers. This study was conducted from first of January 2016 till end July 2016.

The results show that present study found that the responses were really encouraging and promising; out of the 200 respondents (90%) have shown scores of good responses and overall agreement for family medicine in Iraq.

The socio demographic characteristics in the present study including age, gender, years of employment were shown no significant association with the participant's responses. The percentage of agreement carried among statements with highest percentage of agreement was for statement no.1 family physician is the point of first medical contact within the health care system (97 %) and the lowest percentage of agreements was for statement no. 2 (family physician providing open and unlimited access to its users) (61%).

The present study concluded that it reflected the existence of good family physician's role could greatly impact on family medicine and can reflected a promising trend toward changing the current system.

Keywords: General Physician, Family Medicine, Primary Health Care Centers

## INTRODUCTION

Primary health care is high on the agenda of all WHO countries in the world Since Alma Ata conference in 1978 that is called to achieve the global goal "Health for All" and identified Primary Health Care "PHC" as the key vehicle for its achievement to deliver basic health services to all population (World Health Organization 1987). The World Health Organization (WHO) Reported in (2008) entitled "primary health care: now more than ever", has clearly articulated the need to mobilize the production of knowledge on primary care (Organization 2008).

Even though there is general agreement that primary care is the linchpin of effective health care delivery (Boerma, et al., 2006), there is global emphasis on the importance of family medicine, and its role as a cornerstone in the modern health system (Roberts, et al. 2011). Family medicine can be defined as a medical specialty which provides continuing and comprehensive health care for the individual and the family. The scope of family medicine encompasses all ages, sexes, each organ system, and every disease entity. However, family medicine response to the need and the preference of the patients and population, and respectful of patient families, personal values and believes.

In the last 30 years all over the world, primary health care has developed and, increasingly, the awareness has grown that there is need for a specific Medical clinical discipline in primary health care: family physician (Aelbrecht, et al., 2017; Vicini, et al., 2017). The fact that primary care, Particularly family medicine was found to be associated with better health outcomes suggest that family medicine Physicians improving primary care to population (De Maeseneer and Flinken flogel 2010).

The present study aims to explore the attitude of a sample of general physicians working in some primary Health Care centers in Baghdad / AL-Karkh toward family Medicine.

## MATERIALS AND METHODS

Subjects: The design of study is a cross – sectional study, where a convenient sample of 200 general physicians was collected as the source of data it was conducted from first of January 2016 till end July 2016.

The study was implemented at twenty primary Health Care centers in Baghdad/AL-Karkh directorate which were selected randomly: AL-Shabab, AL-Doura, AL-Baya, AL-Saydia, AL-Adel, AL-Khadhra, AL-Jamiaa, Hutein, AL-Gazalia, AL-Huria, AL-Iskan, AL-Tobji, AL-Shaljia, AL-Washash, AL-Yarmouk, AL-Dakhlia, AL-Kadhmyia Alawal, Al-Zahra, AL-Sabiyat, Basheer AL-Jazzairi.

A convenient sample which including 200 general physicians working in the primary health care

centers. The inclusion criterias, from 230 general physicians initially included in our study, only 30 physicians were excluded because either:

1. They rejected the interview.
2. They were outside the primary health care centers due to immunization campaigns or any duty outside the (PHCC).
3. They were on vacation.

Arrangements were done to get approvals from the managers of selected primary health care centers, verbal permission from the participants.

The data was collected by filling the questionnaire which designed for the purpose of the study by WONCA in 2011, prepared by the researcher and under guidance and approval of one community senior specialist.

The questionnaire sheet is a one-page sheet which includes:

1. Social demographic characteristics related to the study group (age, gender, and years of employment).
2. 14 statements of close – ended questions.

The statements were discussing issues related to the specialty of family medicine, starting with family doctor role as the point of first medical contact within the health care system, family doctor role as a coordinator, family doctor role in patient education, family doctor role in continuation of care, comprehensive care, and community – orientation, management of illness, and health promotion and disease prevention.

The responses for each statement are respectively: agree, equivocal, and disagree. The sheet was distributed directly by the investigator and recollected from the participants two days later.

Analysis of data was carried out using the available statistical package of SPSS-22 (Statistical Packages for Social Sciences- version 22). We use quartile system, according to the quartile that is below the second quartile (< 50% of questions) considered as poor. Between the second and third quartile (50 – 75% of questions) considered as fair. Equal or above third quartile (≥ 75% of questions) considered as good. The score of agreement is respectively disagree 1, equivocal 2, agree 3. The score of poor response (< 7), fair response 7 – 34, good response ≥ 35.

## RESULTS

Table 1 shows contribution of the study group according to their age, gender, and years of employment. Doctors age < 40 years (36.0%), doctor's age 40 – 44 years (10%), doctors age 45 – 49 years (19.5%) and doctors age 50 years or more (34.5%). The highest percentage (36.0%) was found in doctors age < 40 year. The lowest percentage was found in the younger generation 40 – 44 years (10.0%). Doctors who are females show high percentage (63.5%) while male's doctors show (36.5%).

Doctors with years of employment < 10 years (15.5 %), doctors with 10 - 19 years (35.0%), doctors with 20 years or more (49.5%). The highest percentage was for those employed 20 years or more (49.5%), while the lowest percentage with years of employment < 10 years (15.5%).

Table 1: Contribution of the study group (socio-demographic characteristics) according to age, gender, and years of employment

| | | No | % |
|---|---|---|---|
| Age (years) | <40 | 72 | 36.0 |
| | 40---44 | 20 | 10.0 |
| | 45---49 | 39 | 19.5 |
| | =>50 | 69 | 34.5 |
| Gender | Male | 73 | 36.5 |
| | Female | 127 | 63.5 |
| Years of employment | <10 | 31 | 15.5 |
| | 10---19 | 70 | 35.0 |
| | =>20 | 99 | 49.5 |

Table 2 shows the responses of agreement of the study group for each statement. Percentage of agreement carried among statements with highest percentage of agreement was for statement No.1 (Family physician is the point of first medical contact within the healthcare system) (97.0%), No.14 (Family physician deals with health problems in their physical, psychological, social, cultural and existential dimensions) (92%) and No.12 (Family physician promotes health and well-being by both appropriate and effective intervention) (90.5%), and the lowest percentage of agreement was for statement No.2 (Family physician providing open and unlimited access to its users), No.9 ( Family physician has a specific decision-making process determined by the prevalence and incidence of illness in the community) and No.11 (Family physician manages illness that presents in an undifferentiated

way at an early stage in its development, some of which may require urgent intervention) respect-tively.

Table 2: the responses of agreement of the study group for each statement.

| | Agree | | Equivocal | | Disagree | |
|---|---|---|---|---|---|---|
| | No | % | No | % | No | % |
| Family physician (FP) is the point of healthcare system within first medical contact | 194 | 97.0 | 5 | 2.5 | 1 | 0.5 |
| (FP) providing open and unlimited access to its users | 122 | 61.0 | 72 | 36.0 | 6 | 3.0 |
| Regardless of the age, sex or any other characteristic of the person concerned family physician dealing with all health problems | 174 | 87.0 | 22 | 11.0 | 4 | 2.0 |
| Family physician makes efficient use of healthcare resources through coordinating care, working with other professionals in the primary care setting and by managing the interface with other specialties | 162 | 81.0 | 32 | 16.0 | 6 | 3.0 |
| By continuous education process family physician promotes patient empowerment | 161 | 80.5 | 33 | 16.5 | 6 | 3.0 |
| Family physician develops a person-centered approach, orientated to individuals, their family and their community | 173 | 86.5 | 24 | 12.0 | 3 | 1.5 |
| Family physician has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient | 166 | 83.0 | 31 | 15.5 | 3 | 1.5 |
| Family physician is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient | 137 | 68.5 | 53 | 26.5 | 10 | 5.0 |
| Family physician has a specific decision-making process determined by the prevalence and incidence of illness in the community | 129 | 64.5 | 64 | 32.0 | 7 | 3.5 |
| Family physician manages simultaneously both the acute and chronic health problems of individual patients | 167 | 83.5 | 29 | 14.5 | 4 | 2.0 |
| Family physician manages illness that presents in an undifferentiated way at an early stage in its development, some of which may require urgent intervention | 130 | 65.0 | 58 | 29.0 | 12 | 6.0 |
| Both appropriate and effective intervention promotes health and well-being by FP | 181 | 90.5 | 16 | 8.0 | 3 | 1.5 |
| Family physician has a specific responsibility for the health of the community | 169 | 84.5 | 22 | 11.0 | 9 | 4.5 |
| Family physician deals with health problems in, social nature life | 184 | 92.0 | 11 | 5.5 | 5 | 2.5 |

Figure 1 shows the contribution of the study group in relation to the score of response. 180 of respon-dents ere shown good response 90%, 18 of respon-dents were shown fair response 9% and 2 respon-dents were shown poor response 1%.

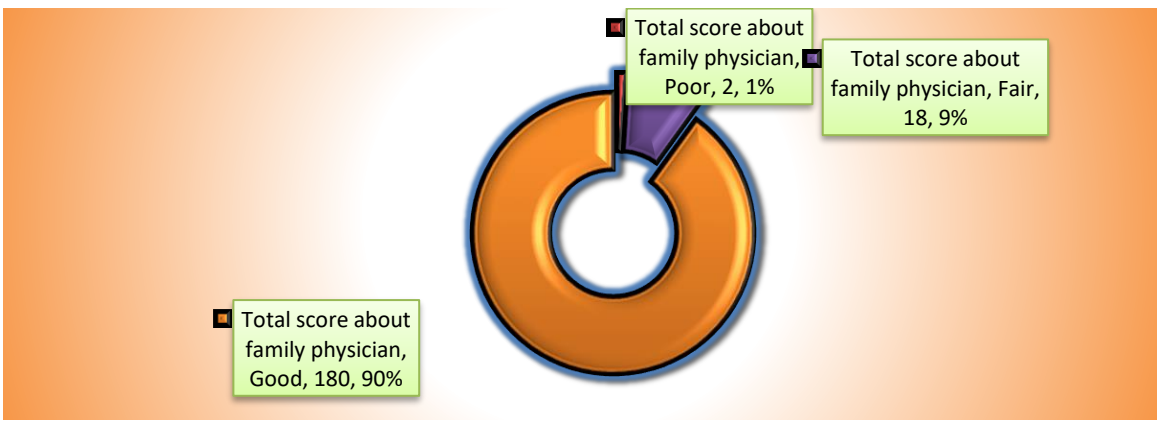


Figure 1: Contribution of the study group in relation to the score of responses

Table 3 shows contribution of the study group scores according to the age, gender, and years of employment. All age groups tended to have good responses. The highest percentage (94.4%) was found in doctors aged < 40 years. The lowest percentage was found in those older generation 50 years or more (87%).

Both males and females tended to have a good response with percentages of (93.2%) and (88.2%) respectively.

All classes of years of employment tended to have close percentages of responses. The highest good responses were 94.3% among those who were employed (10–19 years), and the lowest good responses was (85.9%) among those who were employed 30 years or more. Age, gender and years of employment was found to have no significant association with the participants responses.

Table 3: Contribution of the study group scores according to the (sociodemographic characteristics) age, gender, and years of employment.

| | | Total score | | | | P value |
|---|---|---|---|---|---|---|
| | | Poor-Fair(<35) | | Good (=>35) | | |
| | | No | % | No | % | |
| Age (years) | <40 | 4 | 5.6 | 68 | 94.4 | 0.451 |
| | 40---44 | 2 | 10.0 | 18 | 90.0 | |
| | 45---49 | 5 | 12.8 | 34 | 87.2 | |
| | =>50 | 9 | 13.0 | 60 | 87.0 | |
| Gender | Male | 5 | 6.8 | 68 | 93.2 | 0.260 |
| | Female | 15 | 11.8 | 112 | 88.2 | |
| Years of employment | <10 | 2 | 6.5 | 29 | 93.5 | 0.153 |
| | 10---19 | 4 | 5.7 | 66 | 94.3 | |
| | =>20 | 14 | 14.1 | 85 | 85.9 | |

*Significant difference between proportions using Pearson Chi-square test at 0.05 level

## DISCUSSION

The socio-demographic characteristics in the present study agree with a study was conducted in Iraq in (2005). Another study was conducted in China that shown that 65.4% of doctors participate in the survey support family medicine based health care system.

In the present study, it was shown that (97.0%) of participants agreed that family physician as the point of first medical contact within the health care system and (91.8%) of participants was shown a good response. Sixty one percent of participants agreed that family physician providing open access and (95.1%) were shown good response. This results agreed with another study which was conducted in Spain in (2006) reflected that an effective family doctor is one who follows up the patient over the greater part of his life and who is accessible in the initial phase of his patients' every new problem (Sans et al., 2006). In the present study, around (81.0%) of participants agreed that family physicians make efficient health care through coordinating care and (96.9%) participant was shown a good response.

A similar study results was conducted among 31 European countries plus Australia, New Zealand, and Canada regarding family medicine coordination role took place among physicians between October 2011 and December 2013. The study showed well – coordinated care of family physician in Dutch, Finnish, Lithuania, Iceland, and Sweden.

While coordination cares in Germany, Denmark, Italy, Luxembourg, and Slovakia was not assessed as good (Pavlic, et al., 2015). The variation that found in that study can be explained by variation in physician's characteristics among countries, also the variation among countries which were not equal in primary care situation.

Another similar study was conducted in USA between December (2007) and May (2008) was shown that working relationships between family physicians and other specialists are key to well-coordinated care of family physician. In the present study (68.5%) of respondents agreed that family physicians is responsible for providing longitudinal continuity of care, and high percentage (98.5%) of respondents shown good response.

This result agreed with another study was done in England and Wales, the United States, and the Netherlands, in 2005 that included participants from three differing health care system. The study concluded that family physician have high value on being able to provide personal continuity of care to patients in which the continuity care remain the core value of family medicine and should be taken

account of by policy when redesigning health care system (Stokes, et al., 2005)

High percentage of respondent in the present study (83.0%) recognized that family physician has a unique consultation process through effective communication between doctor and patient. The percentage of good response regarding this point was high (93.4%).

This result agreed with another study which was conducted in Australia in (2007) shown that the family physician ability to communicate well was considered extremely important. The communication and interpersonal skills play a vital role in understanding patient's problems and make it easier for them to express their feelings (Infant, et al. 2004). A high percentage of respondents in the present study (80.5%) agreed that family physician promote patient empowerment; and (95.0%) of these respondents shown good response.

This results were agreement with a study was conducted in Italy in (2008) reflected that family physician is the most suitable for promoting patient empowerment and self – management education to the totality of patients and communities (Mola, et al. 2008). Concerning the process of empowerent, a study was conducted in Belgium in (2006) and show that empowering methods of education are necessarily patient centered and based on experimental learning, and needs to be continuous and self – involving on both sides.

Considering the role of family physician as person – centered approach, (86.5%) of the respondents shown high percentage of agreement, and high percentage of good response (93.1%). Considering family physician role in decision making process (64.5%) of respondents in the present study show agreement, and (96.9%) of respondents show good response. A similar study results was conducted in Texas in 2013 including thirty eight participants and concluded that family physicians perceived their approaches to patient care result in medical decision making priorities and care delivery processes that contribute to more cost effective heath care(Young, et al. 2013).

About (65.0%) of respondents in the present study agree regarding family physician role in management illness at early stage of development. (94.6%) of respondents who agreed also shown good response. A similar study results was conducted in USA in 2002 concluded the family physicians ability to use different diagnostic approaches and process large amount of information into a logical diagnostic and treatment plan (Zoppi and Epstein 2002). Around (83.5%) of respondents in the present study agreed family physician management of acute and chronic health problems, and (93.4%) of agreed respondents also shown good response.

In the present study (90.5%) of respondents agreed family physician role in health promotion, (96.5%) of the agreed respondent regarding this point were shown good response. A study was conducted in Massachusetts in (1996) among primary care physicians that reflected 89% of participants agreed of family physicians responsibility regarding health promotion (risk factor modification, healthy diet, smoking cessation, family planning) (Wechsler, et al. 1996).

In the present study regarding family physician role in community orientation (84.5%) were agreed while (95.3%) of agreed respondents were reflected good response. A similar study results was conducted in Canada in 2000 revealed a more positive attitude towards community–oriented primary care and community–oriented role of family medicine (Oandasan, et al. 2000).

The result of the present study was similar to study was conducted in Iraq(Sans - Corrales, Pujol - Ribera et al. 2006), which reflected that (85%) of respondents were shown scores of good responses and overall agreement toward family medicine.

**conclusion:** Family medicine is a new developed specialty in Iraq, despite that the score of responses for respondents in the study group were really encouraging and promising. The study reflected that the existence of good family physician's role could greatly impact on family medicine, and on the whole health care system and reflected a promising trend toward changing the current health care system in a way that makes it more effective, timely efficient, and equitable. We recommend that family physicians can best continue to develop their skills, apply them within their daily work, self – learning, and self–monitored feedback to be promising approach for become more qualified doctors. Further studies are needed regarding family medicine roles and characteristics in Iraq to confirm whether these characteristics will continue to play a role in the future.

The present study reflected that the existence of good family physician's role could greatly impact on family medicine and can reflect a promising trend toward changing the current system.

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