

**Erasmus+ funded Hippokrates Exchange Programme**

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**Participant report**

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**Vasco de Gama Hippokrates Erasmus+ RCGP Exchange**

**Final Report**

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## **Introduction**

Being a specialist generalist is powerful – and that's something we as primary care doctors often undervalue.

This is at the heart of what I realized during a two-week Vasco de Gama Hippokrates medical exchange programme at the Department of Family Medicine, Marmara University, in Istanbul, Turkey. Meeting other trainees, GPs, and Family Medicine academics, it was inspiring to realise that there exists a worldwide fellowship of doctors like myself who thrive on holistic, evidence based and patient centred care.

During my time in Turkey, I was interested in understanding and comparing the nature of postgraduate GP training, the structure of primary care and the role of the GP. The following article summarises some reflections based on these themes.

## **Primary care in Turkey**

In Turkey patients have free access to healthcare via an almost universal government health insurance policy regardless of employment status. They can approach any primary or secondary care service without charge or a referral. This is of course at odds to how things are done in the UK where we as GPs are usually the gatekeepers of health services and where over 90% of patient contacts occur. Whilst on a different scale, it is also becoming realized that patients in the UK should be able to increasingly access certain services without the involvement of the GP – think IAPT / physiotherapy / some community nursing services.

This system has led to patients approaching specialists for what in the UK would be bread and butter GP territory – for example, cardiologists are commonly consulted for simple hypertension management.

Many of the secondary care clinics that I saw were thus overflowing; this was not necessarily discouraged I'm told, as the specialties receive more money per patient seen. Moreover, part of the reason for this is also because most GPs in Turkey haven't undergone postgraduate specialty GP training and thus are less confident managing common chronic (and some acute) disease.

Seeing this has made me think about the discussions we have in our own context and where the boundary between generalists and specialists should be – for instance, locally we debate whether it is right for a GP to prescribe DOACs or whether it should be cardiologists / haematologists / specialist pharmacists. As I learnt during a tutorial with one of the Marmara University academic GPs, a specialist needs to have time to see niche patients to develop their subspecialty knowledge and experience; a generalist needs to see enough commonly uncommon conditions so as not to become deskilled.

## **Post graduate GP / Family medicine training**

My two weeks were spent with the University's Department of Family Medicine which is responsible for the postgraduate specialty training of GPs.

Admission to family medicine training and indeed any specialty training programme is via a standard exam for all doctors after medical school. Specialties set their pass mark and if achieved a candidate can then begin postgraduate training in this specialty. Psychiatry is seen to be of the most competitive specialties - apparently because it has the best work-life balance – understandably so given a paediatric trainee for example will work 10 night shifts a month (starting at 8am on the first day and finishing at 5pm the next, often with only a stolen 3-4hours of sleep!)

GP / Family medicine training is structured very similarly to the UK. There is 18months in hospital and 18months in family health centres (the equivalent of GP practices). The hospital training consists of fixed rotations that range from one to four months in duration

consisting of paediatrics, obstetrics and gynaecology, internal medicine, psychiatry, haematology and dermatology. The trainees that I spent time with mentioned that they were usually supernumerary in their hospital rotations which meant they were

sitting in outpatient clinics for their learning – with only limited time spent doing ward work. This was shocking given how much of my time during GP training hospital rotations was spent on service provision and filling rota gaps, with little time for GP focused outpatient education.

In terms of assessment in Turkish Family Medicine training, during their rotations there are no formal workplace-based assessments or formal clinical observation sign offs, but rather the specialists will liaise with the family medicine professors to give feedback and any concerns. There are formative exams every year to test clinical knowledge on primary care matters, as well as a final oral knowledge-based exam and a thesis. The thesis is an academic project undertaken over 12-18 months; two examples of thesis projects were: 1) developing an education intervention for parents about when to bring a child for URTI symptoms to be seen by a doctor in ED 2) and another on resilience amongst family medicine doctors.

Once the project is written up, there will be a viva examination to discuss and defend the project's findings.

It was interesting to note the academic nature and openness of the training in Turkey; it seemed quite liberating to not be tied down by the many requirements of the e-portfolio that we have here! The thesis project encourages a development of higher thinking skills in an area that interests the trainee which I quite liked the idea of (if sufficient protected time is given to complete it!). That said, some of the workplace-based assessments we have in the UK are useful in that they provide a platform to develop our consultation skills and encourages workplace learning – which I saw less of in the training system there. From an assessment point of view, it also ensures there is a broader estimation of the trainee's capabilities than simply from the thesis and the knowledge exams. I am told there is a pilot underway in Turkey for a standardized family medicine knowledge and clinical skills exam like we have in the UK.

### **The Consultation and Clinic structure**

I was quite taken aback by the fluidity of GP clinics - where trainees would consult with patients and if there were any queries would co consult with the more senior resident doctor who would walk through the rooms and drop in and help make decisions. I wonder whether this will indeed become commoner in the UK given the rise of nurse practitioners, foundation doctors and paramedics in primary care who are supervised by a GP whose role it will increasingly be to stand back and aid others in decision making. This could help with our waiting times and workloads and, if used appropriately, is arguably a greater use of our skill and experience.

I also noted that permission was not always sought to invite other clinicians into the room, and this would happen mid consult - I imagine patients expect / are used to this and so it is less of an issue. Also, in one instance, three patients (clearly friends) walked in together to talk about contraception and patients would off re-enter the room whilst the next patient was in consult if they had forgot to ask something.

Whilst my kneejerk reaction was discomfort at the lack of confidentiality, there are many contexts where perhaps we all need to be more open with our health. I note recent initiatives where GP practices are trialling and reporting the benefits of group consultations for diabetes and depression.

### **Home visits**

Looking at the role of a GP wouldn't be complete without talking about home visits!

Home visits are conducted by an independent team of GPs and nurses who are separate to the local GP practices. One of the challenges they are facing is that many people expecting home visits have become comfortable with adopting the "sick role" and the problem is often exacerbated by carers. Families feel they are helping their relatives by getting them to rest more as they age, unfortunately this in extremis has led to some

patients becoming bedridden. Physiotherapists and medics are trying their best to counter this narrative.

The patients I saw when on my visits were not dissimilar to those I visit in the UK – frail, elderly patients with impairment post stroke, dementia, with chronic wounds and pressure ulcers etc. It is interesting that there are distinct teams for home visits. This is arguably an efficient way of managing a



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workload which GPs in the UK find difficult to accommodate amidst their many other clinical duties. Such patients are then wholly looked after by the home care units. From conversations with local GPs, they lament that that this system can mean patients lose longstanding relationships with their GP and it also means the GPs lose that holistic oversight of the whole family.

### **General quirks**

Lastly, there were some quirks which made me smile that were universal - clinicians sighing at slow computers, haematology computer request forms filled out with a space or just a full stop, and clinicians always being surprised that I don't drink tea or coffee! Free lunch for all staff at the hospital was a bonus too!

### **Concluding reflections**

My experience has made me appreciate the strong infrastructure that underpins UK General Practice given the absence of this in Turkey. That said, I also reflected on areas where we could do things better, particularly in terms of training. More than anything though this is my first interaction with family medicine doctors beyond the UK; having a fraternity like this inspires pride in our vocation and encourages learning and mutual development and reflection. It has also made me look forward to the prospect of hosting a visiting family medicine trainee and consider how I would show them the guts and glory of being a GP in the UK! I am grateful for the generous hosts who are now friends who took time to host, translate and show me around. The experience was also my first foray into thinking about how health provision is structured, considering what constitutes primary care, and how policy and politics affects the development of a health system and effective patient care. Lastly It also emphasized the merits and value of postgraduate GP training and how it can create competent evidence based expert doctors that are invaluable for local communities whatever their context.

