Undergraduate training of Turkish doctors is very similar to that of English doctors. However, upon completion of five years of medical school Turkish doctors are obliged to carry out an internship year to graduate. This is unpaid. Once graduated, they carry the title of ‘general practitioners’ equivalent to senior house officers in the UK. To specialise they must take their desired speciality’s exam, these cost around TL300. However, it is rare to get the required marks from the first attempt and so they are usually faced with two options. The first is to carry out the government’s obligatory service and the second is to work privately. The obligatory service is where doctors are allocated by the government to work in a rural area for a period of time, this can vary from 350 to 500 days, the more rural the area, the shorter the time.

Once the desired marks for family medicine have been achieved in the specialty exam, the doctor is accepted into a 3-year residency programme. Their title is now a ‘family medicine resident’, corresponding to General Practice Specialty Trainee (GPST) in the UK. Eighteen months of training is spent rotating through all of the major specialities. However, rotations aren’t always the same length of time. For example, rotations through Paediatrics, O&G and Internal Medicine range between four to five months and are significantly longer than those in Psychiatry or General Surgery which can be only one or two months long. The other half of training is spent in primary clinics located in the outpatients department of the teaching hospital. This is called a ‘polyclinic’ and operates like a GP surgery but in a hospital setting.

I had the pleasure of completing my exchange at Pendik’s Educational Primary Care Centre at Pendik Training and Research Hospital. This primary care centre is attached to the hospital’s outpatient department and is run by the residents in the second half of their training. The clinic consists of four consultation rooms, one of which is dedicated to a nurse-led family planning clinic.

A typical working day starts at 9am and it is divided into a morning and afternoon sessions ending at 5pm, partitioned by an official lunch break from 12noon till 1pm. On average, each doctor reviews 27 patients per session. The appointments are made by the patients either online through a central appointment website or by phone using their passport or national ID number and an appointment is usually available one week later. On arrival, the patient clocks-in with the clinic receptionist and the average waiting time to be seen is ten to fifteen minutes. It is up to the doctors, depending on their workload, whether they would accommodate for walk-in patients. Appointments tend to be very brief in which the main issue is quickly addressed and managed, a brief documentation is entered and the next patient called in. Confidentiality is also not as strict as in the UK as patients can be seen with the door open and other patients standing close by. However, this was not distressing for the patients.
The responsibilities carried by the family medicine residents in Turkey are more or less the same as GP trainees in the UK. From my observation in the polyclinic they see and assess their own patients and formulate a management plan according to NICE guidelines. However, senior help is available either in person or by phone and it is easily accessible when required.

The patient’s medication list can be seen and new medication prescribed through a national prescribing system online using the patient’s national ID number. Patients collect the medications via a code and only pay 20% of the price. Blood tests can be requested and results seen on the hospital intranet.

If a referral to another department is required, it is up to the patient to contact the department themselves to make an appointment. Turkish doctors expect their patients to take some initiative towards their healthcare. This is also the case with national screening tests for cervical, breast and colorectal cancers. The patients are expected to request the tests rather than await offers and reminders about them as in the UK. My host explained that the Turkish department of health invests a great deal in media advertising to raise awareness about the importance of these screening tests, that the majority of patients do present to their primary care centre for screening. Those that don’t, are reminded when they visit their primary healthcare centre.

Similar to the UK, family medicine trainees are also expected to carry out home visits to patients who are too ill to attend. The unit usually consists of two doctors accompanied by a nurse visiting approximately three to four patients per day. The visits are either followups of known patients with chronic illnesses or assessments of the needs of newly registered homebound patients. During a typical visit, the nurse would check the patient’s basic observations, draw blood and take a urine sample while one doctor takes a history and examines. The other doctor checks the medication list and documents. A management plan would then be discussed and plans for further visits made. Generally, acutely ill patients are expected to call an ambulance or take themselves to the emergency department rather than wait for the home care unit as it is not an acute service and visits are usually planned in advance unlike the UK where patient’s can request home visits on the day.

The Turkish doctors’ relationship with their patients is evolving. However, it is still more or less paternalistic in that patients submit to the doctors’ decisions and rarely question their authority. Additionally, the time constraints hamper efforts to explore the patients’ ideas, concerns & expectations. Unfortunately, from the patients’ perspective, this lays full responsibility on the doctors and violence, especially from patients’ family members, has been reported in cases where a patient’s health took a turn for the worse despite excellence of care. This has led to an aversion to specialties in which mortality rates are high such as cardiovascular surgery.

Similar to the UK, the professional progression of doctors is monitored and assessed via an online portfolio approved and signed off by their professors following each rotation. Those professors play similar roles to that of the Training Programme Directors in the UK. To successfully graduate from the family medicine training programme, third year residents must carry out a research project and write up a
thesis, following which they must undertake an oral exam. Süheyla, my host, chose to carry our her research exploring the unmet preventative healthcare needs of adult patients of the Pendik Educational Primary Care Centre. Once this research is completed successfully, trainees are then fully qualified family medicine specialist doctors and must now carry out another year of governmental mandatory service in a rural area chosen by the government.

Most specialist doctors go on to work in community-based family medicine centres which are equivalent to GP surgeries in the UK. Each area has it’s own family medicine centre catering for it’s residents and each province has a community healthcare centre coordinating the family medicines centres. Fortunately, I’ve had the pleasure of visiting one of the family medicine centres and receiving a lovely gift from one of the specialists — an interesting book about hospitals in the last period of the Ottoman Empire. I was also pleasantly surprised at how similar the service is to the UK considering it is a relatively new and evolving speciality in Turkey. These clinics function very similarly to polyclinics in a hospital setting as described above except that they are bigger with more doctors. The doctors are paid according to the number of patients registered to their centre and their pay is affected by their compliance with the national standards of care for paediatric and obstetric patients. They are penalised if a child misses their vaccinations or a pregnant lady is not appropriately followed up.

Most of the doctors I spoke to were very happy with their training especially those who are on family medicine rotations. They felt the responsibilities placed upon them were reasonable and that their working hours were mostly compliant with their rotas. Their pay was approximately 1300Euros, this was more fluctuant while in hospital rotations ranging between 1000-1700Euros depending on the number of on calls per month. Those oncalls are resident and are usually 24hours long and during my exchange one of the junior trainees on a paediatrics rotation complained to the family medicine professor about working long hours and being on call too frequently due to poor staffing levels. Doctors are also obliged to buy their own medical insurance, costing approximately 55Euros/year. However, this is dependent on the level of risk in the specialty and length of experience.

Generally the doctors are well respected and looked after. Their midday lunch break is protected for all staff where clinics are paused as staff migrate to the canteen on the hospital’s top floor to be provided with a free three-course meal. Even in community-based clinics, hot food is expected to be served. Turkish doctors were surprised to hear that their counterparts in England are not provided with a lunch meal despite working for the public sector.

To conclude, I have thoroughly enjoyed and learnt from my exchange and I would like to extend my thanks to my host, Süheyla, for her exceptional hospitality despite the deadline of her research closing in and the programme coordinators without whom this exchange wouldn’t have been possible.