A CLOSER LOOK AT FAMILY MEDICINE IMPLEMENTATION IN TURKEY IN REGARD TO THE DOCTOR-PATIENT RELATIONSHIP

Through the Family Physicians' Perspective

by Balacan Fatıma Ayar

KOÇ UNIVERSITY

2017

A CLOSER LOOK AT FAMILY MEDICINE IMPLEMENTATION IN TURKEY IN REGARD TO THE DOCTOR-PATIENT RELATIONSHIP

Through the Family Physicians' Perspective

by Balacan Fatıma Ayar

A Thesis Submitted to the
Graduate School of Social Sciences
in Partial Fulfillment of the Requirements for
The Degree of
Master of Arts
in
Comparative Studies in History and Society
Koç University
September 2017

Koc University

Graduate School of Social Sciences and Humanities

This is to certify that I have examined this copy of a master's thesis by

Balacan Fatıma Ayar

and have found that it is complete and satisfactory in all respects,

and that any and all revisions required by the final

examining committee have been made.

Committee Members:

Asst. Prof. Başak Can

Asst. Prof. Dikmen Bezmez

Asst. Prof. Ayşecan Terzioğlu

Date: 05/05/2017

A CLOSER LOOK AT FAMILY MEDICINE IMPLEMENTATION IN TURKEY IN REGARD TO THE DOCTOR-PATIENT RELATIONSHIP

Through the Family Physicians' Perspective

Balacan Fatıma Ayar

The study is based on 18 interviews with family physicians who work/ed in different neighborhoods and the observations in two Family Health Centers (FHC) with contrasting characteristics in Istanbul. It aims to explore the family physicians' perspectives about the radical transformation in the primary healthcare services. Within the introduction of the Family Medicine Implementation, the general practitioners have transformed into family physicians after short trainings and they started to work as both manager and medical experts in the FHCs. Managerial duties are added to their responsibilities and thus, they are no longer only practicing medicine in the primary healthcare services. One the one hand, family physicians gained managerial and economic autonomy to run the FHCs, and, on the other hand, there is an increasing monitoring of their labor via the performance system in the FHCs, which leads to discussions about the loss of autonomy. Additionally, the emphasis on the satisfaction of the patients and patients' rights is increased as a result of the New Public Management implementations after Health Transformation Program and Justice and Development Party's (*Adalet ve Kalkınma Partisi*) populist policies in health. It transformed patients into consumers/clients and reshaped the doctors and patients relationship in the primary healthcare setting.

This thesis seeks to demonstrate how these neoliberal and populist attempts in healthcare services affect the everyday routine of the FHCs and the doctor-patient relationship in the FHCs through the lenses of family physicians.

Keywords: Family Medicine Implementation, Health Transformation Program, family physicians, neoliberalism, New Public Management, deprofessionalization

Asst. Prof. Başak Can

Institute of Social Sciences, Director
Prof. Zeynep Avcan

Date 05.09.2017

TÜRKİYEDEKİ AİLE HEKİMLİĞİ UYGULAMASINA
HEKİM-HASTA İLİŞKİLERİ ÜZERİNDEN BAKMAK
Aile Hekimlerinin Görüşleri Üzerinden

Balacan Fatıma Ayar

Bu araştırma İstanbul'da aile hekimi olarak çalışmış ya da çalışmakta olan 18 hekimle yapılan mülakatlar ve iki farklı Aile Sağlığı merkezinde gerçekleştirilen gözlem temel alınarak yapılmıştır. Araştırmanın amacı, birinci basamak sağlık hizmetlerinde gerçekleştirilen radikal değişime aile hekimlerinin nasıl yaklaştığını araştırmaktır. Aile Hekimliği Uygulaması'yla beraber, pratisyen hekimler, verilen kısa eğitimler neticesinde aile hekimi oldular ve hem yönetici hem de hekimlik yapmak üzere, Aile Sağlığı Merkezleri'nde çalışmaya başladılar. Sorumluluklarına idari ve yönetimsel bir takım görevler eklendi ve böylece, tek görevleri hekimlik olmaktan çıktı. Aile hekimleri bir taraftan yönetimsel ve ekonomik otonomi kazanırken; diğer taraftan da özerklik kaybı tartışmalarına neden olan performans sistemiyle aile hekiminin emeği artan bir denetime tabii tutuldu. Öte yandan, Sağlıkta Dönüşüm Programı sonrasındaki Yeni Kamu Yönetimi uygulamaları ve Adalet ve Kalkınma Partisi'nin sağlıktaki popülist politikaları ile birlikte, hasta hakları ve hasta memnuniyetine verilen önem arttı. Böylece hastalar tüketiciye/müşteriye dönüşürken, birinci basamaktaki hekim ve hasta ilişkileri de yeniden şekillendi.

Bu tez, sağlık hizmetlerindeki bu neoliberal ve popülist girişimlerin, aile hekimlerinin görüşleri doğrultusunda, Aile Sağlığı Merkezleri'ndeki gündelik rutini ve hekim-hasta ilişkisini nasıl etkilediğini göstermeye çalışmaktadır.

Anahtar Sözcükler: Aile Hekimliği Uygulaması, Sağlıkta Dönüşüm Programı, aile hekimleri, neoliberalizm, Yeni Kamu Yönetimi, profesyonelliğin yitimi

Yrd. Doç. Başak Can

Sosyal Bilimler Enstitüsü, Direktör
Prof. Dr. Zeynep Aycan

Tarih 05.09.2017

ACKNOWLEDGMENT

I am grateful to my thesis advisor Başak Can for her constructive and inspiring criticisms/comments/suggestions and for her steadfast patience. I also thank the members of my thesis committee: Ayşecan Terzioğlu and Dikmen Bezmez. Ayşecan is not only my teacher but also my friend, and she has always believed in me and encouraged me, even before I started my thesis. I have always felt her support and I am extremely thankful to her. I would also like to thank Dikmen Bezmez for her positive behavior and invaluable comments and suggestions. Additionally, I would like to thank the inspirational women in my academic life: professor Nükhet Sirman and my late professor Ferhunde Özbay. I am very lucky to have been their student during my undergraduate years.

I owe so much to my dearest friends: Ezel, Pelin, Sezen, İzem, Erdinç, Deniz Pınar, Koman, Tuğçe, ÖFK, Ceren, Fulya, Tuğ, Kutlu Deniz, Sidar, Cem, and also to my office buddies, Erdem, Onur, and Önder. Ezel, Pelin, and Sezen made the thesis writing process bearable for me with their existence, support and love. I would also like to specially thank Izem for her emotional and intellectual support throughout the years we spent together at Koc. Erdinç, with his naïve and unique personality, was also always there for me. Without his unconditional support, things would have been much harder. If I were able to, I would put a purple heart here for Koman. Additionally, I also would like to thank Arzu for her presence in my life, a presence that empowers me as a woman and to Meryem for her moral support and her belief in me. I also thank my librarian friends Sina and Çiğdem for their endless friendship and help.

I am also grateful to Yeşim Yasin, İlker Kayı, Cenk Özbay, and Ersin Akpınar for their support, encouragement, and suggestions before and during the thesis. Their thoughts and excitement had a profound impact on the way I approached my thesis.

I am indebted to my professor Erdem Yörük who gave me an opportunity to work in the ERC project with him, and I am also indebted to my project coordinators Kerem Yıldırım and Çağrı Yoltar, who made this process doable for me and showed me a great deal of understanding when I was dealing with the thesis and the project at the same time. I also thank Tuğçe for her existence as a friend and a coworker. I am going to miss her friendship, guidance, and patience.

I am thankful to my informants who helped me and shared their experiences for this thesis. Without them, this thesis would not have existed.

I also thank Koc University and TUBITAK for their financial support.

My last thank is reserved for my canım family who are always supporting me. This thesis is dedicated to them: Nesrin, Şükrü, and Mehmet.

CONTENTS

ACKNOWLEDGMENT vi

LIST OF ABBREVIATIONS ix

1. Introduction 1

1.1. Research Methodology 5

1.1.1. Permission Process 7

1.1.2. Interviews 7

1.1.3. Observations 10

1.1.4. Limitations 11

1.2. The Organization of Chapters 12

2. The Operation of the Family Medicine Program in Family Health Centers 13

2.1. Historical Background of Family Medicine Program 13

2.2. Primary Healthcare Services after the Health Transformation Program 15

2.2.1. Community Healthcare Centers and Family Health Centers 16

2.2.2. How to be a Family Physician: Differences between General Practitioners and Family Physicians 18

2.2.3. Referral Chain System 18

2.2.4. Total Payment: Monthly Salary and Current Expenditure Payment 19

2.2.5. Categorization of Family Health Centers 20

2.2.6. Performance System 22

2.3. Conclusion: Family Medicine Program in Istanbul 23

3. Family Physicians as Managers: *Neither Horse nor Donkey; We are Hinny* 25

3.1. Job Definition 26

3.1.1. Managers and Professionals 26

3.1.2. Status of Family Physicians 27

3.1.3. Class and Loss of Prestige 29

3.2. Family Physicians as Managers: Let's Talk About Business 37

3.3.1. Problem Solved: Wi-Fi Connection 38

3.3.2. Sanal FHCs 40

3.3.3. Payment as an incentive: The Story of Two Replacements in the Primary Healthcare Service 43

3.3.4. The Use of the Budget: The Complexity of the Management in the FHC 47

3.4. Conclusion: Do We Ever Talk About Public Health? 50

4. Family Physicians as Medical Experts and Their Perception towards Doctor-Patient Relationship 53

4.1. Deprofessionalization of Medical Experts 54

4.1.1. Labor Control over the Family Physicians and Neoliberal Governmentality 57

4.1.2. Changes in Doctor-Patient Relationship 58
4.2. Satisfaction of Family Physicians from Their Medical Expertise: *Trying to Cure Malaria Constantly without Draining the Swamp* 64
4.2.1. Daily Routine of Consultations in Family Health Centers 64
4.2.2. Familiarity with the Population 70
4.3. Doctor-Patient Relationships in the Family Health Centers 72
4.3.1. Patients with Unlawful Demands and Unjustified Requests 73
4.3.2. Performance System and the Creation of a *Tacizkar* (Disturbing) Family Physician Image 77
4.3.3. SABIM and Complaints of Citizens 82
4.4. Conclusion 85
5. Conclusion: Family Medicine as a *Ragbag* 87
BIBLIOGRAPHY 93
APPENDIX: ORIGINAL QUOTES 99

LIST OF ABBREVIATIONS

AHEF : Federation of Family Physicians' Association (Aile Hekimleri Dernekleri Federasyonu)

Aile-Sen : Family Physicians and Social Services Employer Union (Aile Hekimleri Sağlık ve Sosyal Hizmetler İşverenler Sendikası)

CHC : Community Healtcare Center (Toplum Sağlığı Merkezi)

FHC : Family Health Center (Aile Sağlığı Merkezi)

FMI : Family Medicine Implementation (Aile Hekimliği Uygulaması)

HTP : Health Transformation Program (Sağlıkta Dönüşüm Programı)

IMF : International Monetary Fund

JDP : Justice and Development Party (Adalet ve Kalkınma Partisi, Ak Party/AKP)

NPM : New Public Management

TMA : Turkish Medical Association (Türk Tabipler Birliği)

WB : World Bank

CHAPTER 1

1. Introduction

After the introduction of the Health Transformation Program (*Sağlıkta Dönüşüm Programı*, HTP) in 2003, Family Medicine Implementation (*Aile Hekimliği Uygulaması*, FMI) was put into effect in some parts of the country in 2005. This Program was then expanded to the whole country in 2010. The transformation of the healthcare system with the HTP was analyzed from different perspectives, such as the neoliberal transformation of labor relations in health services, populist policies of healthcare and commercialization of health services (Ağartan, 2012; Cevahir, 2016; Gülbiye Yenimahalleli Yaşar, 2015; Keyder, Üstündağ, Ağartan, & Yoltar, 2007; Sönmez, 2012; Ulutaş, 2011; Yılmaz, 2014). Drawing from the existing research on the transformation of healthcare in Turkey in the last three decades, this thesis examines how family physicians[1] experience this transformation by looking at changes in their understanding of their occupation and their relation to the patients in the Family Health Centers (*Aile Sağlığı Merkezi, FHC*). This thesis aims to shed light on how neoliberal transformation in healthcare unfolds at the everyday level of the Family Health Centers in Istanbul by closely looking at the encounters between family physicians, patients and state officials in the primary healthcare services.

Health Transformation Program

The Turkish healthcare system has undergone a radical transformation with the HTP. However, the background of the transformation dates back to 1980s. The International Monetary Fund (IMF) and the World Bank (WB) provided guidance and were considerably influential in terms of shaping the market economy in Turkey (Ağartan, 2012, p. 457). Throughout the 1980s, the governments introduced several laws and regulations to transform

[1] In this system, there are both family physicians and family medicine specialist (see Chapter 2). However, throughout thesis, I will use *family physician* which represents two of them.

the system in line with the requirements of WB and IMF but their effect was limited (Yılmaz, 2014).

After winning the elections in November 2002, the Justice and Development Party's (*Adalet ve Kalkınma Partisi*, JDP-Ak Party) introduced the HTP in 2003. The primary actors in health sector, such as the Turkish Medical Association (*Türk Tabipler Birliği,* TMA) or health related trade unions were not included in the preparation process of the reform.[2] (Ağartan, 2012, p. 463; Yılmaz, 2014, p. 259). The JDP saw the HTP as a tool to pursue its "neoliberal economic policies and populist social policies" in healthcare (Yılmaz, 2014, p. 155). Many scholars have shown how the HTP contributed to the JDP's electoral victory in the following years. Different from the previous health system, the HTP made sure that a larger number of disadvantaged people have easier access to the healthcare institutions which were closed to them in the previous system (Ağartan, 2015a; Yılmaz, 2014). The HTP is built on the notion of the greater accessibility of healthcare as well as the notions of efficiency and quality (Akdağ, 2009, p. 29). These three goals overlap with the idea of New Public Management (NPM), which became popular first in the UK in the late 1970s as a new paradigm (Smith & Griffith, 2014). NPM is an umbrella term used for improving the economy by lowering public spending, increasing the effectiveness of the public sector with the help of market-like mechanisms and public-private alliances. In this scheme, there are number of changes in the healthcare sector:

> […] reduction in the share of public financing (general budget share) in overall health service financing, or its replacement by the premium system; the spread of "out of pocket" and additional payments, besides contributions to the health expenditures financing by tax and insurance premiums; generalization of private health funds and private individual health insurances; separation of financing and provision of health

[2] The meaning and the consequences of the exclusion from the designing will be explained in the third chapter.

> services; (services) development of the user and provider relations; transformation of health into a market in itself through the establishment of internal markets in health systems; establishment of competitive environment between the autonomy of health service providers and different health service suppliers; pricing of services; performance-based pricing; individualization of risks; sale of public hospitals to private investors and privatizations; increase in new private hospitals; subcontracting; decentralization and establishment of public-private partnerships in the supply and provision of health services (Hermann, 2009; Ünlütürk, 2011: 34-36; Belek and Soyer, 1995; Hamzaoğlu 2009). (Güzelsarı, 2012, p. 40)

The HTP, with its incumbent changes is associated with the concepts[3] such as marketization, privatization, and managerialism. These concepts basically display the market expansion in the public sector from different areas and increasing visibility of private sector when it is compared with the past (Ağartan, 2012). The weights of their proportion in the healthcare sector are changing, depending on the aims of the health policy of JDP.

> Although the role of the private sector is growing slowly in service provision, the trend towards marketization is clear, with greater emphasis placed by the policy elite on the virtues of private provision and growing pressures on public hospitals to become more market-oriented. (Ağartan, 2012, p. 466)

In Turkey, marketization was first introduced with the *quasi-market*[4] understanding since Turkey's "state-dominated healthcare system'' (Yılmaz, 2014, p. 37). Additionally, the entrance of the quasi-market logic into healthcare after HTP gradually turned citizens into

[3] Marketization refers to the transition from a planned economy to the market-oriented economy including such as liberalization of economic activity and market logic in the public sector. Privatization is a process of transferring from publicly controlled units such as property, industry, service to the private sector. Managerialism (see also *New Public Management* in page 2) is used for the new kind of organizational relationships which enhanced with the managerial ideology including control mechanism in an organization.

[4] Quasi-market is specifically designed for reconciling market behaviors with the public sector in Britain especially after 1980s (Hudson, 1992).

clients. For example, the HTP gives citizens with health insurance "a free choice among the public and private hospitals, though they have to pay additional chargers to private providers according to the criteria determined by the Ministry of Health," (Ağartan, 2012, p. 466) as well as providing them with the premise/guarantee of satisfaction from their healthcare services. The priority is given to their demands as customers of health rather than their actual need from healthcare services (Güzelsarı, 2012; Ulutaş, 2011).

The focus on satisfaction of the citizens either though populist policies, which increase accessibility to health care services, or through a quasi-market understanding, which prioritizes healthcare choices of well-off citizens above anything, might bear the risk of undermining the satisfaction of the workforce in health sector. It is within this framework that I focus on the experiences of family physicians that epitomize one of the most radical transformations introduced by the HTP.

Family Medicine Program

With the HTP, privatization and entrepreneurial logic have entered into the primary healthcare service. Family Medicine implementation becomes one of the representatives of the hybrid version of management and medical profession in the healthcare system under the FMI.

FHCs constitute a focal point where neoliberalism, the state, and managerial and professional practices intertwine intensely on the basis of FMI. The replacement of the Health Centers with the FHCs has resulted in radical changes in the management of the operations and the doctor-patient relationship in the primary healthcare setting. General practitioners' salaries were paid for by the government and general practitioners were considered civil servants in the primary healthcare services until 2005. After 2005, they were gradually turned into contract-based employees who work for government (Ulutaş, 2011, p.41).

With this change in their job description, FHCs are now run by family physicians but financed and inspected by the state. Family physicians are managers but at the same time are managed by the state. Family physicians are both contractors and exposed to new managerial control mechanisms introduced by the state (Warwicker, 1998). It creates confusion in family physicians' status. On the one hand, family physicians take the whole responsibility for running the FHCs with the given current expenditure payment, and, on the other hand, the performance system is introduced "to subordinate and control professional practice" in the FHCs (Warwicker, 1998, p. 203). This transformation significantly affects the healthcare workforce's work satisfaction, because they face problems concerning their job security and rights as health workers.

Doing an institutional ethnography in the FHCs allows us to see the complexity of the implementation of Family Medicine and their impact on family physicians' experiences. The aim of the thesis is to understand the effects of the transition from the previous model to the FMI from the perspectives of the family physicians who experienced this transformation in their day-to-day practices as (1) managers, (2) medical experts and, especially, (3) in the encounters with their patients in the FHCs. The chapters are organized around these three dimensions of family physicians' experiences at the FHCs. Before summarizing my chapters, let me introduce my research methodology.

1.1. Research Methodology

I use qualitative research methods and my thesis is constructed from interviews conducted with 18 family physicians as well as my observations in FHCs. I bring family physicians' encounters and experiences to the center of my analysis. Focusing on the experiences of family physicians, my research aims to understand the everyday routines and practices in the FHCs.

The family medicine system has been in use in Istanbul for more than six years. I conducted participant observation in FHCs and conducted interviews with family physicians for over two years. I was able to see how the system was constantly changing during my two years of research. I observed the changes in the written regulations regarding the family medicine system as well changes in the everyday of the FHCs.

The data was collected by conducting semi-structured interviews and making observations in two different FHCs in Istanbul. I chose Istanbul as my field because of its dynamic structure in terms of high population density and its resourceful and idiosyncratic characteristics, such as sharp class and cultural differences in different neighborhoods. It turns out these differences significantly affect the establishment process and workings of the family health centers. Despite the universality of the rules regarding how to establish a FHC, the process of opening a center greatly varies due to factors such as the location of the FHC, category of FHC, use of budget, personality of coworkers, work experience and registered population of the family physicians. Thus, the experiences of each family physician has unique characteristics. During the analysis of the interviews, I tried to contextualize the narratives of physicians to show why and how their understandings of a similar topic differ.

In addition to the fieldwork, in order to formulate the outcome of the interviews, I also got familiar with the discourse of both the JDP government and the TMA through their official documents, NGOs' reports, and media search, and I conducted additional interviews with family health workers, academicians, and members of TMA and other NGOs', and attended conferences. I attended the *International Eastern Mediterranean Family Medicine Symposium* in Adana in 2014 and 2015 and the *Annual International Family Practice Congress* organized by Federation of Family Physicians Association (Aile Hekimleri Dernekleri Federasyonu) in Antalya in 2015. I also read reports by TMA, The Federation of Family Physicians'

Association, Ministry of Health, World Bank (WB), and other related associations' reports. Lastly, I read related regulations by the government published in the Official Gazette.

The most significant part of the fieldwork was the interviews with family physicians. Other sources of data was gathered (1) not to get lost in the family physicians' discourses which may lead one-sidedness and (2) to look at the topic from multiple perspectives to preserve the critical gaze.

1.1.1. Permission Process

The permission process took longer than I expected. I sent my application to the Public Health Directorate of Istanbul (*İstanbul Halk Sağlığı Müdürlüğü*) in December, 2015. My documents were sent to Ankara to the Public Health Institution of Turkey (*Türkiye Halk Sağlığı Kurumu*). Since research topics like family health worker's satisfaction is evaluated in Ankara, the Public Health Directorate of Istanbul was not able to make decision about my thesis. In these situations, the Public Health Institution of Turkey evaluated the application, and I was able to receive permission in April, 2016. The regular procedure takes about two months; however, in my case, it took more than four months.

1.1.2. Interviews

I conducted 18 semi-structured interviews. Since all interviews were conducted in FHCs, I visited 15[5] different FHCs in 8 different districts in Istanbul. 7 neighborhoods can be considered as a slum and/or a lower-middle class neighborhood, and 8 of them were upper-middle and/or upper-class neighborhoods.

Four of my informants were new in the FMI. Fourteen of my informants have been in the FMI since the beginning of the Program in 2010. Six of them had worked at the Health

[5] In two FHCs, I conducted interviews with two family physicians, separately.

Centers (*Sağlık Ocağı*) with varying years of experience until the FMI. Five of them had experience in Health Centers during their compulsory service and then worked in different departments and sectors in health. Three of them had just started to work in 2010 with the FMI. One of the interviews was conducted with a family physician who had resigned from the FMI and started to work at Community Health Centers (Toplum Sağlığı Merkezi, CHC) in a lower-class neighborhood.

At the beginning of the interview process, I relied on the reference of an acquaintance to contact family physicians. After eight interviews, I decided to find interviewees by calling them one by one without any reference. To prevent hearing familiar narratives, I randomly chose FHCs among the ones that I wanted to visit and telephoned them to arrange an interview with one of the family physicians in the Center.

I had two different questionnaires for interviews. The first questionnaire includes additional questions for the ones who had experience in Health Centers. I asked questions to make them compare the working conditions and doctor-patient relationships. The other questions are the same in each questionnaire, aiming to collect the data of family physicians' personal information and medical background; family physicians' registered populations' characteristics and the neighborhood where their FHCs are located; family physician's experience in FHCs as managers and professionals and their satisfaction from their job; their working conditions; daily interactions with the patients; (if any) membership to any union/federation/NGOs; and, lastly, their thoughts on the current health reforms. The follow-up and wording of the interview questions may have changed according to the interview. Depending on family physicians' willingness to talk, available time and talkativeness, the questions listed above were shortened/not asked/expanded. I conducted most of the interviews

after working hours in the FHCs. The shortest interview was about 30 minutes and the longest one was more than 2 hours.

One problem I experienced was that the family physicians sometimes told stories which were not related to their daily routine in FHC. In such cases, I tried to direct them to their own personal experience in the FHCs.

Another problem was to get access to family physicians who work in neighborhoods which can be counted as conservative and low/middle class districts. I did have three different phone calls to three different family physicians working in such neighborhoods. One of them refused to participate during the phone call by saying that ‘’I’m sickened with the system and I don’t want to say anything about it.’’ The other one said that I could visit her. However, when I went there for interview, she was gone without any notice. She asked too many questions about what and why I am doing this research and why I choose that FHC specifically.

By selecting informants, I consider the cultural and socio-economic specialties of the FHCs’ region, I did my calls according to a balanced distribution of the neighborhoods. Also, I paid attention to family physicians’ years of experience in medicine in order to create an equal distribution.

All interviews were conducted and transcribed by me. All interviews were on voluntary basis and the interviewees’ consents were taken. Before the interview, I explained the purpose of the research and gave the necessary information about the interview process. Except two interviews, all of the interviews were recorded. For the other two interviews, I took notes. One of the interviewees who refused voice recording said that “It would be as if she was giving away her ID number if her voice is recorded.”

Before the interviews, I informed participants about the purpose of this thesis and took their consents accordingly. Anonymity and confidentiality is provided for each family physician. Real names are not used in this thesis and any identifying information of family physicians is not given.

1.1.3. Observations

At first, I decided to make my observations at four different FHCs and applied for permission accordingly. However, I limited my observation to two FHCs. During the interviews, I had a chance to observe the working conditions and the operation of many FHCs, so I decided that these were enough to support to my interviews. I took notes during the fieldwork in these two FHCs. I chose FHCs with contrasting characteristics in order to get familiar with different neighborhoods, different working conditions and the population profile of patients. These FHCs and their locations are anonymized to preserve family physicians' privacy.

The first FHC has three units and it is located in an upper class neighborhood. During my two days of observation, most of the visitors are elderly people and janitors who work/live in the apartments in the neighborhoods and their wives and children. There were few pregnant people or those with their children in two days. I was able to talk with the family physicians in this FHC and they were kind and helpful to me.

The second FHC is located in a slum and it has six units. However, one of the units was empty. There were five family physicians working there. In contrast to the first FHC, I did not have a chance to contact with family physicians even though I introduced myself. They were not really interested in why I was there or what I was doing there. I spent more than four hours in this FHC, and it was very crowded and most of the patients were mothers and children. The

family health workers in the vaccination room were always busy when I was there. Even though nurses were busy with vaccinations, they spared some time for me to talk.

Another interesting and determinant factor which shows the contrast between the two FHCs is the communication between patients and patients; patients and family physicians; and family physicians and family physicians. In the first FHC, family physicians, nurses and patients organically and easily communicated with each other. There is a small waiting room and the atmosphere is calm and relaxed in there. However, in the second FHC, because of the crowd and largeness of the waiting room, there was a constant background noise. The first one was tidy, shiny and organized, while the latter was chaotic, separated and dark.

Making observations was beneficial for me to see, first hand, the details about the daily routine of the FHCs. As a result, I became more competent during interviews while they were talking about spatial differences, the facilities' characteristics, intensity of the patients and coworkers' communication behaviors. I did not only listen to family physicians but also saw what happens in the FHCs. It was helpful for me to follow the narrative flow of interviewees.

1.1.4. Limitations

In the following chapters, I briefly mention the relationship between family physicians and the family health worker (*aile sağlığı elemanı*) including nurses, midwives and health officers in the FHCs. I did not include their experiences in FHCs since (1) my focus is only the family physicians and (2) their position is worth examining in terms of the "deskilling" of their occupation, which requires sepereate and more comprehensive analysis. Although the idea of teamwork is praised by the government for FMI, calling nurses, midwives, and health officers as 'family health workers' has created a different kind of hierarchical structure in the FHCs, and it has both positive and negative sides for family physicians and family health workers.

1.2. The Organization of Chapters

The thesis consists of five chapters. The second chapter presents the historical background of the primary healthcare services and continues with the implementation of the Family Medicine. It aims to introduce the significant components of the FMI. Therefore, it explains the FHCs' position in the healthcare organization scheme, the requirements of being a family physician, (failed) referral chain system, the constituents of the total payment of family physicians, the categorization of FHCs and, lastly, the performance system.

The third and the fourth chapters focus on the effects of the financial concerns, spatial differences, policy-making processes and patients' behaviors on the experience of family physicians. These factors will be discussed according to the daily experiences of family physicians in the FHCs and encounters of family physicians with the state, administrators in the CHCs, coworkers and family health workers, and registered population.

The third chapter addresses how family physicians position/represent themselves regarding the discussion of combination of managerialism with the medical profession in the FHCs. The main discussion will be around the hybridization of managerialism and the profession, rather than the effects of managerial responsibility of family physicians in FHCs. It focuses on specific cases to capture the encounters of family physicians in different positions.

The fourth chapter focuses on practicing the medical profession. How and in which conditions family physicians experience their expertise in FHCs will be analyzed with the outcomes of the fieldwork. In addition, it specifically investigates the family physicians' perspective on the doctor-patient relationship in the primary healthcare centers.

The concluding chapter summarizes the main chapters of the thesis and makes an overall analysis of each of the components which constitute the family physicians' experience.

CHAPTER 2

2. The Operation of the Family Medicine Program in Family Health Centers

Since the beginning of the Family Medicine Implementation (FMI), family physicians have been facing reforms that aim to privatize primary healthcare services. The Ministry of Health introduced a new form of organization in the provision of primary healthcare that seeks to decrease its financial responsibility and reduce the total cost of healthcare spending (Ulutaş, 2011, p. 189). The stated aim of the Ministry of Health is to reduce its financial responsibility in the long run. However, close surveillance of family medicine workers occurs through the performance system and ordinary/extraordinary inspections (*olağan/olağandışı denetim*) by Public Health Institution of Turkey, Public Health Directorates, local authorities and/or the ones that are responsible for them[6]. If they cannot meet monthly performance targets, family physicians are paid less. Reducing the cost by leaving the management part of Family Health Centers (FHC) in the hands of family physicians and increased surveillance of the primary healthcare staff are the two major differences from the previous primary healthcare system.

In this chapter, I will introduce the historical background of the FMI by looking at the healthcare policies and practices which paved the way for the Health Transformation Program (HTP) before its implementation and then move on to the description of the FMI with its important features.

2.1. Historical Background of Family Medicine Program

With the Law on Socialization of Healthcare Services (1961) (*Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun*), Health Centers were established to serve a population of 20.000 in metropolitan areas, 10.000 in provincial areas, 5.000 in districts and 2.500 in villages (Mehtap Tatar et al., 2011, p. 121). These health centers are staffed by general practitioners,

[6] http://www.istabip.org.tr/4250-aile-hekimlerine-yonelik-olagan-disi-denetimler-hakkinda-bilgi-notu.html

nurses, midwives, health officers, and environmental health technicians (Mehtap Tatar et al., 2011, p. 121). The expansion of health centers to provide primary healthcare services in Turkey ended in 1984. Although it spread all around the country, there were serious problems in its implementation. The expectation was that it would create an integrated healthcare system which would provide preventive and curative healthcare services in each region. Nusret Fişek (as cited in Cevahir, 2016, p.73) arrays the number of reasons for the failure of the implementation: "distrust in socialization program, lack of sufficient number of general practitioners in Health Centers, lack of cooperation between health centers and hospitals, not paying the personnel allocations, and lack of support in equipment and medications."

Turkey's privatization and liberalization efforts in the healthcare sector started with the International Monetary Fund's (IMF) Stabilization Policy and World Bank's (WB) Structural Adjustment Program in the early 1980s. On the national level, the responsibility in health has shifted to a supervisory and regulatory role with the 1982 Constitution Act[7] and it means that the state has started to take action towards reducing their role in healthcare services. Günal describes the changing role of the state and public sector with the transition to the neoliberal era as follows:

> Although the promotion of the private sector was emphasized before the 1980s, its actualization in the proper sense had to wait for the transition from national developmentalism to neo-liberal capitalism. Within the context of this transition that occurred in the late 20th century, efforts that were made to diminish the role of the state and the public sector was found inefficient due to the lack of competition. (Günal, 2008, pp. 396-397)

These developments also prepared the ground for the "promotion of the private sector" in healthcare (Günal, 2008, p. 396). The 6th Five-Year Development Plan (*Altıncı Beş Yıllık*

[7] http://www.saglik.gov.tr/TR,11472/tcanayasasi-56madde.html

Kalkınma Planı) (1990-1994) introduced the management logic into the healthcare system explicitly for the first time. The plan had regulations concerning the implementation of modern management practices into the healthcare system (*Altıncı Beş Yıllık Kalkınma Planı 1990-1994 (Sixth Five-Year Development Plan 1990-1994)*, 1989, p. 290). As it can be seen, the promotion of market logic in health care gradually diffused with the following five-year plans, laws and regulations.

Family Medicine was regarded as a major element of privatization and managerialism in the healthcare system in Turkey. Adopting a family medicine model has been on the agenda of health care reformers in Turkey for more than 20 years dating back to the early 1990's. The earliest attempt to introduce the family medicine model was made in 1993 with the National Health Policy (*Ulusal Sağlık Politikası*) prepared by the Ministry of Health. In addition, during the '90s, the WB and government began to cooperate to implement a series of reforms in health care on the grounds that the Turkish health system was in need of radical re-structuring (Yılmaz, 2014). One of the components of the Health Reform of 1990s is the "development of the primary health services in the framework of family medicine", especially in the cities (Akdağ, 2009, p. 19). However, these attempts did not come to fruition until the HTP was launched in 2003 and the implementation of Family Medicine in 2005.

2.2. Primary Healthcare Services after the Health Transformation Program

The HTP was launched in 2003. One of its eight components was the family medicine model. Accordingly, Law no. 5258 on Family Medicine Pilot Implementation passed in 2004, and the Family Medicine Program was first introduced as a pilot program in Düzce in 2005 and was extended to cover the entire country by the end of 2010.

According to the family medicine model, family physicians provide primary care to the population on their lists. The aim is to create an easily accessible health service to a local population by establishing family medicine programs, creating a referral chain system, and

giving administrative and financial authority to health facilities (Akdağ, 2009, p. 21). Family physicians are expected to have general information about a family medicine system, a referral chain system, and administrative and financial aspects of running a family health center.

I will provide detailed information regarding these characteristics in the following sections.

2.2.1. Community Healthcare Centers and Family Health Centers

With the new reorganization in the administrative hierarchy in the primary healthcare services, there are now Community Health Centers (*Toplum Sağlığı Merkezi*, CHC) under the Ministry of Health, Provincial Directorate of Health (*İl Sağlık Müdürlüğü*), and Public Health Directorate (*Halk Sağlığı Müdürlüğü*). In Turkey, there are 971 CHCs and 39 of them are in Istanbul (Gökler et al., 2016). While FHCs are responsible for individuals' health, CHCs aim to provide healthcare for the public (Gökler et al., 2016, p. 57). CHCs serve in each district (*ilçe*) and one of the duties is to inspecting and supervising FHCs.

CHCs are designed to protect, detect, and improve public health standards, and coordinate and monitor primary healthcare services.[8] They provide logistical and technical assistance to FHCs while supervising and monitoring FHCs on behalf of the Public Health Directorate (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013, p. 7).

FHCs are staffed by at least one family physician and family health personnel to provide primary healthcare services such as immunization of infants, follow-ups for pregnant women and infants, home visits, family planning services, and elderly care (Mehtap Tatar et al., 2011, pp. 122-123). Some of these services, such as monitoring of registered pregnant women (at least four visits), and periodic follow-up visits of registered infants, are included in a performance

[8] http://www.resmigazete.gov.tr/eskiler/2015/02/20150205-5.htm

system. The preventive healthcare services listed above are the performance targets, and they have specific capitations, which constitute some part of the salary. Details about the relation of preventive healthcare services with the payment and performance system will be examined in the following sections about the total payment and performance system.

Family physicians are responsible for an average of 3,500 people[9] and the aim is to decrease this number to 2000 by 2023.[10] The high number of population per family physician is a very important problem for sustainability of the system. FHCs also suffer from a shortage of medical specialists or an imbalance in the distribution of personnel.[11] As a solution to these problems, government authorities sought to promote compulsory services and provided incentives to encourage personnel to work in less desired regions to counter the general tendency of working in the developed regions (Akdağ, 2009, p. 90).

According to the Health Transformation Program Assessment Report (Erkoç, 2012, p. 110), family physicians voluntarily apply for available positions and, if they have the necessary service score, they are assigned to the neighborhood where a FHC is/was established. To motivate doctors to apply for these positions, they were paid relatively higher payments especially during the first years of the FMI.[12] If publicly paid family physicians decide to leave

[9] http://www.resmigazete.gov.tr/eskiler/2010/05/20100525-10.htm

[10] http://www.euprimarycare.org/column/primary-care-turkey

[11] One of the reasons for the imbalance of the distribution of personnel is that doctors are able to choose the FHCs they work in. In Istanbul's case, less desired places are slums and/or neighborhoods or places away from the city centers. They are continuously updating the situation of the occupancy rate (*doluluk oranı*) of the FHC units in IHS's website (http://www.istanbulhalksagligi.gov.tr/data/content/AH_yerlestirme_verileri/asb.html). The reasons for changes in occupancy rates may differ. The first major reason for this is the increased number of FHCs in Istanbul after FMI with Sanal FHC (Virtual FHC). However, the deficit of family physicians does not correspond with the number of FHC units. Therefore, especially in districts with high population density, the number of empty units increases. Another reason is the preferences of family physicians. In this system, they are able to choose their FHCs by lottery. It creates an imbalanced distribution of personnel, and as a result, less desired FHCs remain empty. It is impossible to differentiate the effects of the two reasons which create empty units. For instance, in August 2016, there were 4.136 open vacancies in Istanbul and 386 of them were empty in Istanbul. The top five districts with empty units are listed here with the number of the empty units: Esenyurt (43), Küçükçekmece (24), Bağcılar (24), Gaziosmanpaşa (22), and Avcılar (22). According to a Life Quality in Istanbul Research (İstanbul'da Yaşam Kalitesi Araştrması) (Şeker, 2015), the four areas excepting Küçükçekmece, are districts with the least life quality among the 30 districts, with the respective ranks Avcılar (27), Bağcılar (28), Gaziosmanpaşa (33) and Esenler (35). As a consequence, the reason for the general number of vacancies is the result of the deficit of family physicians, and the reason for the imbalanced distribution is the family physicians preferences.

[12] This kind of generous salary policy that aims to encourage doctors was also used in different periods in healthcare services (Cevahir, 2016, p.63).

the system for any reason, they are transferred to CHCs or Emergency Services. They receive a lower salary but continue to have job security (Ozsahin, 2014, p. 60).

2.2.2. How to be a Family Physician: Differences between General Practitioners and Family Physicians

In Turkey, there is a distinction between general practitioners and family physicians. While every medical school graduate can work as a general practitioner, being a family physician requires an additional three years of training with a specific focus on curative healthcare services (Günal, 2009, p.489). The first Family Medicine department was founded in 1984 in Gazi University (Günal, 2009, p.489).

There were a small numbers of Family Medicine specialist in Turkey during the establishment of the FMI. Even in 2015, the number of family medicine specialists working at FHCs was 1.212 while there were 20.484 general practitioners in the FHCs (Köse et al., 2016). During the transition, the shortage of family physicians in the late 2000s and early 2010s was ameliorated with short-term trainings for the new FMI to respond effectively to the needs of primary healthcare services. After a short training, a general practitioner can become a family physician but not a family medicine specialist (Metsemakers, 2012, p. 27). Later, additional and continuous educations and trainings are given to family physicians including online trainings, regular educational trainings, and re-training programs.

2.2.3. Referral Chain System

The explanation for the delay of the gate-keeping system is about the lack of family physicians and the inadequacy of infrastructure in Turkey[13]. Ideally, gate-keepers should be the first contact of the patients in the healthcare system. The role of the gate-keeper is providing

[13] http://www.ailehekimligi.com.tr/?Ctrl=HTML&HTMLID=1665&t=Sevk_Zinciri_Uygulamasina_Suresiz_Erteleme

coordination of care by referring their patients to specialists in necessary situations, decreasing waiting times in hospitals, and reducing the workload in the secondary healthcare services.

One of the aims of the FMI was to constitute a referral chain system. It was tested in some pilot provinces after the introduction of HTP but it did not work as it was planned. After a number of failed trials, the referral chain system was postponed indefinitely (Health System in transition, p.33). Patients can go to each level of healthcare services in Turkey for now. The failure of referral chain system resulted with the continuity of the pressure on hospitals (Günal, 2008, p.489).

2.2.4. Total Payment: Monthly Salary and Current Expenditure Payment

A family physician's salary consists of current expenditure payment (*cari gider ödemesi*) and monthly salary.

2.2.4.1. Monthly Salary

If a doctor decides to join the FMI, he/she would have a two-year contract and be assigned to a specific population, which varies from 1,000 to 4,000 registered citizens. If the registered population increases, monthly salary increases correspondingly. The level of socioeconomic development of the region is also a determinant of the monthly salary. But the most important factor in determining the monthly salary is the number of performance targets reached. Performance targets such as follow-ups of pregnant women and vaccination of registered infants and children also increase the monthly salary and they are calculated with specific coefficients. If a family physician does not meet the requirements of the performance target, his/her payment decreases accordingly.

2.2.4.2. Current Expenditure Payment

The current expenditure payment is given to the family physicians to make sure that they run the FHCs. They were expected to take the responsibility of the management of FHCs

in the name of the State. Yet, they are also subject to ordinary or extra-ordinary inspections by other state officials. In short, the current expenditure payment has (at least till very recently) motivated many doctors to become a part of FMI system in which they earn more than they could earn in hospitals. They also earn more than doctors who used to work in the previous primary health system. However, in contrast to the previous primary health care system, family physicians are in charge of paying rent, managing utilities (wi-fi, phone, electricity, water bills), buying office and medical equipment, and even hiring a secretary. These expenses are paid collectively by all the family physicians working at the same FHC. Instead of directly administering FHCs, the state delegates this administrative role to the family physicians and shows itself only in the routine and unusual inspections of the medical equipment and the required materials of the FHCs.

With the current expenditure payment, family physicians gain managerial and economic autonomy. The stated aim of giving budget responsibility to family physicians is to create cost-effectiveness in the primary healthcare services in accordance with the efficiency claim of the HTP.

When family physicians decided to improve the FHCs' conditions, they get higher current expenditure payment depending on the category of FHC. In the next section, I will discuss the categorization of FHCs and how the categorization system works.

2.2.5. Categorization of Family Health Centers

Each FHC is categorized under labels of A, B, C, or D depending on its quality standards, which are specified in the Family Medicine Implementation Regulation. Depending on the category of the FHC[14], additional payment is given to family physicians to ensure that

[14] There are also non-categorized FHCs. At the beginning, if a FHC does not correspond with any quality standards, FHCs are classified like this. However, after family physicians meet the standards, within the categorization of FHCs, they get additional payment.

the needs of FHCs are covered (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013).

Each FHC under the category D should have at least 20 square meters of waiting area (with a device such as an LCD or a plasma TV) and employ cleaning staff. In order to be included in Category C, it is required to have a vaccination and monitoring room in the premises. Also, a midwife, a nurse, an emergency medical technician or a medical secretary must be employed. For Category B, an additional room for family planning and pregnancy follow-ups, an electronic system for showing the list of waiting patients, intrauterine device application, and flexible overwork practice are needed. FHCs receive the highest current expenditure payment if they are listed under Category A. For this, they need to have at least 14 square meters of examination room per family physician, an additional emergency response room, a breastfeeding room, a disabled toilet, and a website for FHC.[15] Family physicians can aim to upgrade their category after reaching a consensus with other family physicians to meet the costs jointly.

In addition to this categorization of FHC, there is another characteristic of FHC: Sanal FHCs (Virtual FHCs). Sanal FHCs are mostly in regions with high population density and with an insufficient number of FHCs. The category of Sanal FHCs are thought of as a solution. As I mentioned before, there were open vacancy positions in Istanbul and most of them are Sanal FHCs[16]. It means that there is no proper building/apartment in the neighborhood where a family physician is assigned to provide primary healthcare. Therefore, family physicians have to find the proper FHCs and they are responsible for paying the rent of the building/apartment.

[15] http://www.resmigazete.gov.tr/eskiler/2015/03/20150311-4-1.pdf

[16] 10th footnote explains the general reasons for the emtpy vacancies. Another reason which is not comparable with the previously mentioned reasons is that whether the FHC to be applied is a FHC or not can also determine if the family physician will work there or not, due to financial concerns. (I will provide an example of the problems with sanal FHC with Coskun's case in the next chapter.)

Since there is also a need for finding/buying furniture and equipment for the FHC after finding a building/apartment, newly opened units are supported for ten months with extra payment. Most of these centers, which are opened from scratch, have required large investment and it has caused problems for family physicians. Since the Sanal FHCs are an important feature for examining and understanding the FMI, the case of Sanal FHCs will be analyzed further in the next chapter.

2.2.6. Performance System

How the performance system affects the monthly salary was briefly mentioned above. In this part, the definition and the implementation of the performance system will be explained in more detail. Family physicians and other medical personnel in FHCs are evaluated by a performance system. Each member has monthly performance targets which mostly include preventive care practices such as immunization of registered children for each target vaccination, 4 antenatal care visits of the registered pregnant women, and follow-up visits for registered babies and children[17] (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013, p. 9).

According to the capitation formula, having more pregnant women and children under five generates higher monthly salaries, and it means that family physicians with a higher number of performance targets gain more money. Concordantly, it creates more workload and responsibility to meet the performance target. In the previous system, having a low performance did not result in a family physician being fired nor did it result in a salary deduction. Today, family physicians are measured by their performance and the contracts of family physicians can be terminated for repeated failure to meet the specified performance targets. They are obliged

[17] The emphasis on the reproductive health in the primary healthcare services can be discussed under the neo-conservative and pronatalist behavior of JDP (MacFarlane et al., 2016). Since this thesis is limited with the examination of the neoliberal and populist policies on health, the focus is not expanded to examine this situation through the pronatalist practices of JDP.

to meet at least 90% of the performance target. On the one hand, the surveillance of medical experts with the performance system holds family physicians accountable, while, on the other hand, it results in improvements in immunization and antenatal/postnatal health of the women (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013).

2.3.Conclusion: Family Medicine Program in Istanbul

Throughout the chapter, I briefly introduced the important components and the features of the FMI with a short historical background of FMI in Turkey. This chapter can be considered as a guide for the next two chapters to explain the conditions of FMI and to create familiarity with the terms.

Before going further with the experiences in FHCs, discussing how family physicians think about the implementation of Family Medicine in Istanbul is crucial. When discussing methodology, I explained the reasons why I decided to make my fieldwork in Istanbul. Istanbul has very dynamic features in terms of mobility and it contains different poles, including cohabitation of people with cultural differences and social class differences. In my opinion, this fluid and complicated structure affects the FHCs because of the fact that FHCs are planned as the first-contact care of the health service. Besides, the average number of population per family physician in Istanbul is 3.953 while it is 3.629 in Turkey (Köse et al., 2016). Istanbul represents an efficient field for this study, as it not only has diversity that can be representative of Turkey in general but also has its particularity due to its intensity. It affects the workload of the family physicians and, due the other factors mentioned, seeing the implementation in Istanbul can allow me to collect fruitful data.

Three family physicians made a comment about the implementation of Family Medicine in Istanbul, and one of them thinks that the transformation from Health Centers to FMI was *paldır küldür* (rushed):

> No one predicted, especially in Istanbul, that we would pass to a new system. It was said that we would pass in 2010, 2011 but we expected it to be extended, because Istanbul is a big city. It was a sudden transition and everyone learned by on the fly. It's not possible to learn with that two-week training. Of course there was disorder in the beginning but everyone learned by doing. [...] in that sense it was rushed but it was established. As is the case in many things, it just happened. (Bilge) [1][18]

The other two think that the system should have been applied differently according to the characteristics of the locations:

> This system would work out perfectly in Düzce but not in Istanbul. It's a vast space, since it's a city it's hard for this system to work here. They need to make an exception for Istanbul. (Can) [2]

> You do it this way, as we structure health we do it in the same manner all around Turkey. This is fundamentally wrong. For instance, for Istanbul health should be structured differently. For the periphery it should be different. (Mert) [3]

The emphasis on the thoughts of family physicians about the implementation in Istanbul is given here in order to keep these comments in mind while reading the following chapters. The next chapter will scrutinize how family physicians react to taking managerial responsibilities in the FHCs after the JDP's reform on health.

[18] Statements of the family physicians are enumerated. Original quotes are provided in the Appendix.

CHAPTER 3

3. Family Physicians as Managers: *Neither Horse nor Donkey; We are Hinny*

The Health Transformation Program (HTP) has reshaped the relationship of family physicians with their occupation and medical expertise because of their new roles as the Family Health Centers' (FHC) administrators. In the previous primary healthcare system, the everyday routine consisted of "examining patients, prescribing medications, administering vaccinations, discussing and dispensing birth-control, identifying and tracking pregnancies, and performing tasks such as giving injections, stitching wounds or treating burns" (Önder, 2007, p. 209). With the transformation of the system, family physicians are now responsible from a number of administrative tasks besides the routine primary health care practice. The newly introduced performance criteria that aim to create an accountable family medicine practice put an extra pressure on these physicians.

In her analysis of the previous primary health care system, Önder argues that primary healthcare centers are the "representative of the state" (Önder, 2007, p. 208). Today primary healthcare centers do not only represent the state, but, maybe more importantly, they represent a very peculiar entrepreneurial logic of the HTP introduced by the state. FHCs turn into representative places to see how "the traditional boundaries between professional and managerial ways" are blurred into each other (Correia, 2016, p. 2). This chapter aims to show how the entrepreneurial and quasi-market tendency transform the nature of professional work, as family physicians take managerial responsibilities in FHCs. I will examine how Family Medicine Implementation (FMI) develops management and control systems through family physicians by focusing on how family physicians experience the managerialist turn in FHCs. Drawing on their work narratives, I will first discuss their understanding of their changing class position and new managerial responsibilities. I am also interested in the ways in which the state responded to the material and emotional grievances of family physicians.

3.1. Job Definition

Family physicians, as medical experts, are the primary actors of the transition to the new FMI, which is based on the hybridization of the logics of managerialism and professionalism. In the following, after explaining the notions of managerialism and professionalism, I will discuss how the boundaries of public and private are re-drawn through the practices of family physicians.

3.1.1. Managers and Professionals

Parsons emphasizes the difference between managers and professionals as follows:

> […] the business man has been thought of as egoistically pursuing his own self-interest regardless of the interests of others, while the professional man altruistically serving the interest of others regardless of his own. (Parsons, 1939, p. 458)

Like Parsons (1939), Exworthy and Halford also highlight the dichotomous usage of the notions. Managers are defined as "conformist, self-interested, and career motivated," and, as opposed to the managers, professionals are introduced as "creative, altruistic, and driven by ethical commitment to their expertise or at least, by commitment to their profession as a way of securing status and privilege" (Exworthy & Halford, 1999, p. 1) in the popular and academic discourse.

Family physicians as medical professionals turned into "managerial professionals" or "quasi-managerial practitioners" (Causer & Exworthy, 1999, pp. 83-84) in FHCs. In the following section, I will show how this transition was made possible through material changes in the organization of FHCs and how these professional workers ended up defining themselves as contractual-based employees working for the government.

3.1.2. Status of Family Physicians

I interviewed 18 family physicians working in different neighborhoods in Istanbul. Some of them are new in the system, and some of them have been working in the healthcare services more than 25 years. I asked them what they think about being a family physician and, after a while, I understood that the public-private dilemma and quasi-market logic which ensued in the implementation affected their answers. Then, I changed my question to '*how do you define family physicians' status*?' During the interviews, I came across various opinions on how family physicians define themselves. Being a subject in the middle of the public-private dilemma of the healthcare services has a direct relation with their status. The ambiguity of public-private status creates confusion for family physicians' because of the fact that they cannot always know their position vis-à-vis the state.

In terms of adaptation to the change in the public sector, some of my interviewees have already made clear/direct attempts to embody the new practices of the job. HTP cannot be independent of ''the individuals who constitute organization image and behavior" (Halford & Leonard, 1999, p. 107). As Halford and Leonard (as cited in Halford & Leonard, 1999, p.107) argue, ''change will only take place if individuals 'live out' or 'embody' new practices''. Their stories vary drastically. Some of my informants were willing to work at FHCs after the launch of FMI and they made a considerable financial investment in their FHCs. Some of them have great success stories with high levels of satisfaction. Another one has stories filled with court cases and expenses, which resulted in resignation, dissatisfaction and distress.

Murat works as a family physician in an upper-middle class neighborhood and the registered population of his unit is approximately 3.500 people. He describes his neighborhood as peaceful and his population as upper-middle class, educated, and elderly (mostly retired). He sees approximately 40 patients per day, and has no problem with other family physicians and medical staff working there. He is usually critical of the system and the negative effects of

populist policies of the government on the health care system[19]. I asked the question about the family physicians' status and, for him, their status is changing depending on the state's will:

> We don't really know what we are. Are we a private business or public institution? Because depending on its needs, the state sees us as public or private. […] You know, there is a saying: 'neither horse nor donkey'. We are hinny (*Ne at ne eşek; katırız biz aslında)*. It is not clear what we are. [4]

Ersin, with more than 25 years of experience in medicine, also agrees on the effect of changing practices on family physicians. He likes the place he works and his registered population. However, he is also aware of the problems of the FMI. For him, administrators can use the ambiguity of the implementation as a tool and he said:

> For instance they define you as a private institution, sometimes as private other times as public. So the administrators see you whichever way they want. Because you don't have specific laws. [You are subject to] article 657[20] on the issues of investigation and discipline; [You are considered as] private when it comes to management. [5]

The working agreements of the FHCs are made with the governorship. Therefore, in terms of administration, FHCs are private businesses. However, family physicians are subject to civil servant's law in case of a disciplinary situation. Some of the family physicians I interviewed like Murat and Ersin clearly show the confusion in their minds and display the duality of the status.

[19] The effect of the populist policies will be examined in the third chapter with a focus on the doctor-patient relationship.
[20] Law No. 657 of July 14, 1965 on Civil Servants. Civil servants work for/employed in the Ministries.

There is a range of variation in the level of one's commitment to the logic of professionalism or managerialism. Depending on where they want to see their status, they position themselves according to their perspectives.

Another family physician, Coşkun[21] resigned from a FHC and started to work at Community Health Center (CHC) in a lower-class neighborhood. He was passionate about the new the FMI in Istanbul. Then, he decided to be a family physician and made a considerable investment on his FHC but it ended in failure. In the new system, family physicians do not have a chance to choose their nurses. The idea of the FMI is to encourage teamwork between the staff in the FHCs but it does not work well in every FHC. Coşkun had problems with nurses and he complains about how he is not allowed to manage the staff, even though these doctors function as "managers". Nurses who worked with Coşkun made a complaint about Coşkun for his bossy behavior and he defends himself saying: "I have never considered myself as a boss before, but in this system, I said I am the boss and it was accepted by those who are reasonable. However, nurses made a complaint about me. [6]'' Family physicians are the managers of the FHCs in the new system. Despite this title, there are limitations that do not allow them to act more autonomous such as selecting their own partners or medical staff.

I have so far shown family physicians' conflicting thoughts about being a family physician in an FHC. In the following section, I will explain how administrative duties and their ambiguous status affect family physicians in practice as they work as healthcare providers.

3.1.3. Class and Loss of Prestige

The existing scholarship points out that there is a widespread belief among the doctors that with the introduction of the performance system and increased use of populist policies in the healthcare services especially in the last two decades (Ağartan, 2015a; Dorlach, 2016;

[21] Coşkun's case will also be separately analyzed in the Sanal FHCs part as a case study in this chapter.

Yılmaz, 2014), the prestige of medical profession, the economic and symbolic privileges of physicians, were challenged (Yılmaz, 2014). However, we also observed that there are strong economic incentives for physicians to opt for being a family physician. In this section, I examine the contradictory consequences of the ongoing transformation of healthcare on the social and economic status of FMIs.

According to Bourdieu (1984), class analysis cannot be reduced to economic relations, because class analysis has more complex and symbolic relations within itself, which refer to both Marx and Weber. Weber's treatment of class is associated with multidimensionality which includes ‘'property, occupation, authority, education, and prestige" (Wacquant, 1991, p. 47). Unlike Weber, Bourdieu does not distinguish class from status. While Weber is constructing this multidimensionality through class and status, Bourdieu sees interrelation between these class and status groups rather than considering them to be separated elements of a whole (McDonald, 2014, p. 903). In the context of family physicians, doctors’ loss of prestige in the public eye after the transformation of health care system affects the status of the doctors, which is related to the symbolic relations[22].

When the economic conditions of family physicians are considered, much higher payments are, when compared with the previous system, given to family physicians, and this creates strong economic capital for some family physicians, such as the ones who do not have to pay rent for their FHCs from their current expenditure. On the other hand, they are controlled and monitored to appraise their medical expertise via the performance system quantitatively. Additionally, their working definitions have several characteristics in common with both civil servants and business people, and as a result they are both employers and employees in the FHCs. Another contrast is that, while family physicians have a chance to develop different

[22] I will specifically explain what I mean by losing prestige and decreasing authority of the family physician in the Deprofessionalization of Medical Experts part of the fourth chapter.

consumption habits when compared with the previous healthcare services' doctors, anxiety and insecurity come into their life because of the lack of guarantees and security in the FHCs. Therefore, a holistic view is required that recognizes all these influencing factors to create the neoliberal subjects in their uniqueness.

Hakan, as mentioned above, works in FHCs in a slum neighborhood and he prefers not to use his current expenditure for the FHCs but, rather, he uses it as part of his salary. During his short-term experience in the Health Centers, he was earning approximately 1.500 TL six years ago. Today, he earns approximately 8-10.000 TL. He has created an expectation with the higher salaries:

> In the end, we are soldiers of capitalism. After this age, I know I cannot change the system. I also want free healthcare but it does not happen. We are both defenders and victims of the capitalist system. I have to live a good life; I have to leave things to my children. [7]

> Do not get me wrong, I am a soldier of the capitalist system. My job is to earn money. I am a typical example. … I am a doctor, that's my job at the end of the day. I want to live my life well. I want to eat good food; I want to go to good places. That's my concern. [8]

He criticizes the system but accepted its neoliberal continuum. He finds a way to survive in the system while not paying all the current expenditure to his FHCs and tries to balance his payment and labor in his own way. The system also helps him in doing so. There is no strict control mechanism for the spending of the current expenditure. Inspections are only made for the equipment check, not for controlling the quality of the equipment and hygiene of the FHCs. His story is important because he wants to use his profession to have a good life and he does not make concessions for his profession. He prioritizes himself and that makes him a typical

example of the emerging NPM discourse as a subject in the primary healthcare services in Turkey.

Bilge is a family physician, and when I interviewed her she had been in the system for three months. She has twenty years of medical experience. Before working as a family physician, she worked as a director of one of the CHCs. Then she decided to go back to doctoring. While working as a director, she had faced several stories including the problems of family physicians, monitoring of FHCs and complaints from patients about their family physicians. Working in a CHC means that a person has several stories about the problems family physicians face, monitoring of FHCs and complaints from patients about family physicians. It means Bilge has a chance to see the FMI from both perspectives. Also, her previous experience in the Health Centers gives her a chance to compare it with the previous system. In the light of this information, I asked her opinion about the doctors' loss of prestige and patients' respect for them. She thinks that the medical profession is always respected but this respect has diminished and she says:

> There is no sharp contrast. I cannot say that the patients do not respect this or that but everyone is harping on the same string as they did in the past: "your salary is paid with the taxes I pay." It has turned into this now: 'they do not kill you for nothing'. The discourse has transformed into a more violent thing. [9]

Bilge argues that the government policies have provoked patients with a wrong strategy and it resulted in this kind of consequence even it is not common in FHCs but in emergency rooms and hospitals.

In the next chapter, the role of the reform and the changing behavior of the patients with their consequences will be elaborated in detail with the discussion on deprofessionalization. Now, I will move on to the changes in the mobilization of the family physicians and

problematize the newly emerged employer's union of family physicians to show how it enhances the confusion of the status of family physicians.

3.1.3.1. Mobilization and Unionization of Family Physicians

TMA[23] was against the Family Medicine Implementation when it was first launched. TMA sees HTP and thus Family Medicine Implementation as a project of IMF and WB which prioritize the privatization of healthcare (TMA, 2011). In the following years, the TMA's attitude towards FMI has slightly changed, but they continued to fight against privatization in health care. Kadir who is a family physician in an upper-middle class neighborhood and has an active role in the Family Medicine Branch of the TMA criticized the TMA's passive role at the beginning of the Family Medicine Implementation and then explains how TMA changed its position:

> TMA was a bit late for Family Medicine. TMA started to actively move after a long time. […] TMA was against the family medicine system because it relies on the free market economy. […] TMA says that money shouldn't interfere with the doctor-patient relationship because anyone should be able to access the free healthcare services. Therefore, TMA was against family medicine system years ago. Unfortunately, this reaction has resulted in not being able to defend family physicians' rights. TMA did nothing for it. After a while, we intervened and now we make an effort to make the system better and fight for the family physicians' rights. [10]

[23] "Today, TMA is a public corporate entity that works under the purview of the MoH. However, in practice, the TMA works independently from the MoH and acts more like a non-governmental organization'' (Yılmaz, 2014, pp. 174-175). There is a conflict between JDP and TMA because of its opponent view to JDP's conservative behaviors in politics in general and neoliberal policies on health. TMA declared their criticism to HTP with these five factors (as cited in Yılmaz, 2014, p. 183): "the reform results in the privatization of health care services; the reform is the replica of neoliberal health care reforms that have been imposed by the WB on developing countries; the reform leads to the deterioration of working conditions for medical doctors and other health workers; the reform leads to an increase of violence against health workers; and the reform results in the dissolution of teamwork among medical doctors and other health workers by introducing performance-based payments and increasing subcontracting within the sector.''

They especially argue for the status of the family physicians. Registration to the TMA is necessary if a doctor works in the private sector. In 2011, there was a disagreement between the Ministry of Health and the TMA because of the status of family physicians. The Ministry of Health stated that family physicians are civil servants; thus, they do not necessarily register to the TMA. However, the TMA argued that since family physicians pay rent and insurance premium on their own, their status is not a civil servant. Kadir said that there is an ongoing lawsuit for the clarification of the family physicians' status. Membership of family physicians to the TMA has become complicated because of the ambiguity of the status.

As the counter-position of the TMA to the FMI continues, a special union was established in 2013: Family Physicians and Social Services Employer Union (*Aile Hekimleri Sağlık ve Sosyal Hizmetler İşverenler Sendikası,* Aile-Sen). Lütfi Tiyekli, the union leader, made a press statement about the status of family physicians. He drew attention on how the State uses this ambiguity of the status. According to him, the Ministry of Health behaves arbitrarily and sometimes categorizes family physicians as civil servants and sometimes as employers depending on the situation. The union was officially established and it means that their *employer status* is officially confirmed by the authorities. Aile-Sen's existence is also problematic for some family physicians that do not see themselves as employers but as employees.

Can, as mentioned above, is a family medicine specialist and provides services to an upper-middle class neighborhood where the majority of the registered population is non-Muslim and elderly citizens. He sees himself as a *müteahhit* (contractor) who guarantees to work for government. His opinion of the union and his civil servant status is as follows:

> I also do not accept the status of a civil servant; there is no such thing. If a civil servant is a worker who works for the state, yes, we are civil servants. If a civil servant means

> a worker who works for government, yes, we are civil servants. We, in terms of status, who sell our labor, our medical profession, nursing labor, are workers. Therefore, our union has to be a workers' union. [11]

By establishing an employer's union, some family physicians accept the ongoing process of privatization. At this point, the difference between Aile-Sen and the TMA is the perception towards the ongoing process. On the one hand, consolidating and conforming steps for the HTP's objectives are taken by Aile-Sen, and, on the other hand, a resistance of family physicians can also be observed in the TMA's position. The expectations from the system are a very crucial determinant on the Family Medicine Implementation. Some of them want the continuation of the system with minor regulations, some of them are still against the service system totally and some of them are only against the ambiguity of the practice. Most of my interviewees expressed that "[that] are at the bottom of the ladder'' in terms of mobilization and defending their rights. For instance, Kadir thinks that unions were not qualified to deal with or familiar with family physicians problems before; however, after the Saturday shift and its threatening language from the Ministry of Health, they started to pay more attention to family physicians' problems.

So far, I explained how different positions are assumed for the *created* ambiguity of the family physicians in terms of mobilization and unionization. Now, I will provide an example to show how medical *elites* started to take action for their rights. Gouldner's contribution to the middle-class discussion is to show the poles of the 'New Class': emancipatory attitude and elitism (Gouldner, 1979). Family physicians were forced to do shifts at emergency rooms and also to take the Saturday shift at FHCs. This case will explain how family physicians become a member of unions and start to attend to the protest with an *emancipatory attitude*.

3.1.3.1.1. The Effect of Mandatory Shift Practice on Unionization and Mobilization

The Ministry of Health added additional working hours as a requirement for family physicians (Agartan, 2015, p.1625). However, this did not last long. Before examining the effect of the mandatory shift practice on unionization and mobilization, I want to talk about the applicability of the shifts by the family physicians in FHCs. Can is a family medicine specialist and works in an upper-middle class neighborhood. He refused to attend to shifts because he thinks that it requires another specialty and equipment and this is not part of his job description:

> This is not an appropriate place for shifts. We cannot provide service as Emergency Rooms. We don't have the structure for it. Neither [do we have] the personnel nor the equipment. Nevertheless, they told us to do so. [12]

FHCs are not appropriate places to provide emergency care for the patients. However, the government forced the shifts. The Council of State (*Danıştay*) passed a law about the shift procedure by taking a position with family physicians in March 2015.[24] There were a number of protests and strikes to react to the imposition of the shift practice. In May 2015, there was the 3-days-long strike in Turkey. Family physicians were reacting to the mandatory Saturday shifts and penalty points which are also defined as a negative performance. The Ministry of Health threatened the family physicians with recision. In addition to strikes or protests, family physicians did not attend the mandatory shifts on Saturdays. Some family physicians did not attend the shift protest individually and others acted collectively as part of a mobilization.

For instance Bilge, who is a union member and failed to remember her union's name at first, does not attend her shifts with her coworkers. She thinks that it is an electoral investment but not a demand from the citizens and she refused to attend the shifts. One of her reasons for being a member of the unions of family physicians is to take precautions against legal cases

[24] www.radikal.com.tr/saglik/danistay_aile_hekimleri_nobet_tutmayacak-1323309

arising from boycotting shifts. I think some family physicians like Bilge may have a tendency to become a member of the unions not because of the importance of the mobilization and/or collectiveness but because of pragmatist concerns[25] such as legal support for their cases if required.

The perception towards mobilization differs. They can be very distant to the mobilization or they are not familiar with the concept of mobilization. Ulutaş also argues that family physicians have pessimistic views for developing a solidarity among themselves (Ulutaş, 2011, p. 266). Therefore, there is a lack of unity among family physicians. Despite this, the participation (also activeness) of family physicians in the unions, chambers, and associations increased, especially after the "mandatory shift regulation" that was put into effect in 2015. They started to organize and protest more consciously compared the previous years. As an achievement of the protests, the law on the mandatory shift practice was repealed in 2016[26].

3.2.Family Physicians as Managers: Let's Talk About Business

Agartan evaluates the HTP and its effect on the health workforce and she exemplifies family physicians' situation like this: '' […] primary care physicians found themselves to be operational managers of their own practices without much training or preparation'' (Ağartan, 2015b, p. 1622). After a short training during the transition, general practitioners become family physicians but not family physician specialists. Without a proper education, they start to work as family physicians and learn what they should do as family physicians in the field. The logic of '*kervan yolda düzülür*'[27] (One makes up as s/he goes along) affects their experience.

In the following parts of this section, I will exemplify their manager positions with different examples of their experiences and encounters in the FHCs.

[25] I think this pragmatic concerns need to be elaborated in the discussions of middle-class and mobilization.
[26] http://www.hurriyet.com.tr/aile-hekimlerinin-cumartesi-nobetleri-kaldirild-40222291
[27] Arda was talking about the unprepared transition to the family medicine program, especially in Istanbul. He will be introduced in the following pages.

3.3.1. Problem Solved: Wi-Fi Connection

I have visited two different FHCs in Istanbul. One of the FHCs is in a very wealthy neighborhood and their registered population consists of rich (mostly elderly) people and the relatively poor doormen and their families living in the neighborhood. FHC is shared by three family physicians. The category of the FHC is D. The waiting room is well organized for patients but does not have much daylight. Family physicians' rooms are spacious, hygienic and tidy. In the second day of my observation, the Wi-Fi connection was disrupted. One of family physicians bought a 4 GB mobile Internet plan and shared it with other family physicians and the problem of Wi-Fi was solved. When family physicians face administrative or operational problems in the FHC, they have to find their solutions with the budget given by the state. It is no longer the responsibility of the state. In this case their solution was to buy an Internet package. If they were not agreeable, oriented toward problem solving, and solidarist, the problem would have turned into a nightmare for them. Since they do not have a chance to choose their partners in the FHCs, disagreements might occur on the operational level. For instance, Ayben and Coşkun resigned from the system and one of their reasons is disagreement with other family physicians. Coşkun thinks that since he is responsible for the management of the FHC, he has to be able to choose his 'partner' in this system. However, the system does not allow you to choose your 'partner' in the FHCs. When Coşkun worked in the FHC, one of family physicians had been working with him for 7-8 months and she started to work in another FHC without letting Coşkun know. According to Coşkun's claim, she did not share the payment of the previous month's rent, the bills of the electricity, water, phone and the Internet. In the end, he failed to receive her share and says:

> I failed to receive the money. I just can't. Why? In any business, for instance in a grocery with 2-3 partners, when someone leaves the business, you sit and reach an agreement, don't you? Unfortunately, in the FHCs, sometimes the Internet, water, bills, rent contract

is under one family physician's responsibility. My partner has applied for other available vacancy and left the FHC and I cannot even take the money that she had to pay for administrative tasks. Also, you cannot do anything legally in this situation. [13]

This is the loophole of the system. Although the operation in the FHCs looks like a private clinic, they are not counted as business-partners. In practice, there are many stories resulting with serious disagreements between family physicians, which may interrupt the running of the daily routine of the FHCs. If I go back to the Wi-Fi problem, in Coşkun's case, it may have also finished with a disagreement. If one of them had refused to share the Internet package, the others may have ended up buying it themselves since it has become costly. As a result, the system may have collapsed and the record of the follow-ups' and examination's data may have been interrupted because of the lack of Internet connection in the FHCs. And since their solution mechanisms for the problems are not controlled by the state, family physicians could have said that 'there is a system failure and we cannot accept patients today'. Instead, they bought an Internet package by sharing the cost of the Internet plan from their individual current expenditure payments and solved the problem. However, in Coşkun's case, his coworker refused to share the expenditure of the FHCs. These are the alternative scenarios for this specific problem for not sharing the current expenditure payment and not working in coordination.

The state gives initiatives to run the FHCs but there are loopholes which can leave space for arbitrariness in practice. It results in dissatisfaction and confusion among family physicians, conflicts between family physicians and other medical staff, and also problems with the patients.

The next part will demonstrate the Sanal FHC problems of the family physicians.

3.3.2. Sanal FHCs

Sanal FHCs deserve a close look in order to see the complexity of the operational steps of the primary healthcare system. By 2010, almost all Health Centers of the previous system had been transformed into FHCs. However, the quota for family physicians of primary healthcare services increased and as a result, the old system's buildings were numerically insufficient. In some areas, there were no proper buildings/flats to be assigned to family physicians. They were expected to find their own buildings/flats and furnish it with medical and office equipment to provide primary healthcare services to the citizens. The state supports family physicians with an extra current expenditure during the first ten months, but they still need investment, which is not to be covered with the current expenditure payment provided to family physicians to establish an FHC.

Depending on the location of the FHCs, the rent of the building/flat changes; in wealthy neighborhoods, rents are very high and mostly unaffordable for family physicians. Therefore, the number of vacancies for per unit is determined depending on the location of the FHC. For instance, Adnan provides services to upper-class citizens living in a wealthy population with six more family physicians in the same FHC. It means that Adnan and his co-workers have to find a proper place for seven family physicians. A larger building/flat means higher rent. Therefore, sometimes it is not possible to find a building/flat in such a neighborhood. The solution for Adnan's FHC is to move to another neighborhood under the condition of serving to the same registered population. Can says:

> You cannot say to family physicians: 'go, open a Family Health Center.' You can say it in Bayburt. With the current expenditure, they can handle it. But if you want to open a Family Health Center for five people that can comply with the current regulation in *X*, you can't. [14]

In cities like Istanbul with high population density and high rents, family physicians are having difficulties finding a proper place for medical examination. The FHC needs to fulfill minimum requirements like the number of rooms per FPs and proper square meter for each examination room, which was mentioned in the previous chapter. For these reasons, Adnan had to find another place in the adjacent district and open the FHC there.

After finding a proper place, the problems of Sanal FHCs continues mostly because of the sharing expenses. Finding a proper place was problematical for the first attendees of the system, especially in 2010. I will give an example of Coşkun who faced the difficulties of the Sanal FHC. He was ready to "internalize the managerial norms" in the medical setting despite being against the privatization of healthcare. He mentioned that he was totally aware of the system's future aim in terms of privatization although there is not a clear declaration from the authorities on the privatization attempt. Although he is against the paid-health service, since he lives in a capitalist society, he decided to integrate into the system. Family physicians could choose their working district depending on the order of their seniority. Since Coşkun recieved priority because of the years of experience, he was assigned to his choice, which was one of the upper-middle class districts in Istanbul. He started searching for a place for providing primary care with two other family physicians. Because of the high rent and not being able to find a place that meets the requirements, these two family physicians have given up for searching for FHCs. They left Coşkun alone and continued to search for another FHC on their own. He says: "I found a place alone. I have pounded the pavement for almost a month and I have worn off a pair of shoes" [15]. Most of the Sanal FHCs are not designed for specific medical environment. Therefore it may need variety of renovations, which also leads to credit debts for family physicians who were not supported enough financially[28]. Because of these reasons, the other

[28]http://www.istahed.org.tr/haber-istahedsanal_ASM_ve_tek_hekimli_ASM_lere_iliskin_raporumuz-175.html#.WFUFGFN97IV

two family physicians that have left Coşkun alone were resigned from FMI with at 100.000 TL losses:

> The other friends, since their salaries do not correspond with the rent of the building and the operating expenses, they failed. That's exactly what happened! They failed. They have invested approximately 125.000 TL. They turned a place like a barn or basement into a very good FHC with their own money. Later, since we are doctors but not businessmen and do not having a comprehensive knowledge of business, they went down into a business. They have left the FHC with 100.000 TL in debt. [16]

They are now managers but they do not have experience in managerial duties and the architectures of the HTP did not prepare them properly. Halford and Leonard (1999) argue that in a traditional sense, professional identities are not capable of ‘"bureaucratic procedures, organizational politics or even interpersonal (management) skills" (p.105). It is not something that can be generalized. However, there were general practitioners who did not have managerial experience until FMI and all of a sudden they turned into managers of the FHCs.

If I continue with Coşkun's case, his investment on his FHCs has failed just like his first partners. He has faced problems of finding partners in Sanal FHC because of the unfavorable conditions of Sanal FHCs such as higher expenses and the requirement of the investment. Another family physician came to the FHCs as the second family physician but he only stayed for one and half month. Later, he passed on to another FHC which is not Sanal FHC because he does not want to spend more money for the expenses of Sanal FHC.

Ideally, when a family physician goes to another FHC or resigns from FMI, they transfer their equipment to the next family physician with a specific price or take what it costs from their partners in the FHCs. Another option is taking them away with her/him. On paper, it has to be like that. However, the legal procedure does not always work in the field like in Coşkun's

previous case and in the example of the Wi-Fi section. At the end of Coşkun's story, he resigned from being a family physician, leaving lots of investigation and court files behind and now he lives with five truckloads of medical and office equipment in his home.

However, all these Sanal FHC cases do not end negatively. For the sake of comparing Coşkun's case with a satisfactory example of Sanal FHC, I will explain Arda's case shortly. Arda entered the system in 2010 while he was working in the private sector. He was a manager in the pharmaceutical industry, which means that he has some knowledge on management. His FHC, which is located in lower-middle class neighborhood, belongs to the municipality and he works with two other family physicians. They only pay 1.000 TL for rent in total. He said that they spent around 50.000 TL for renovations and medical and office equipment for the FHC at the beginning and their system worked without a problem.

There is no structured or uniformed practice when family physicians encounter with problems. Every experience is new and every time they are expected to find their own solutions and agree with each other at some point. The trajectory of the process also depends on the personal characteristics and the working experiences of family physicians like we see in Arda's and Coşkun's cases. The regulation does not satisfy the needs of family physicians when a disagreement occurs and therefore, they should reach their mutual agreement without the hands of the state, which can be very problematic. The elaboration of how personal choices, characteristics, and even a bit of luck affect the operation of the FHCs is examined in the following part.

3.3.3. Payment as an incentive: The Story of Two Replacements in the Primary Healthcare Service

One of the aims of the HTP is to create cost-effective healthcare services and to reduce the financial and administrative responsibility of the state in primary healthcare services. As a

solution for this desire is to cut expenditures (Güzelsarı, 2012), current expenditure payment as a budget to run the FHCs is given to family physicians. To encourage medical experts to be a part of the FMI during the transformation, higher payment was used as an incentive. It is an important incentive, especially for those who worked in the previous system as a general practitioner and made little money. Mert who works in an upper-class neighborhood as a family medicine specialist, makes a comment about it:

> If you employ people with one thousand Turkish liras for 20-25 years and then put five thousand Turkish lira in their pocket all of a sudden, at the first stage, doctors will be satisfied, healthcare staff will also satisfied. But later people started quitting instead of joining the system. [17]

Physicians who experienced the previous system are satisfied with the new system's payment policy. However, in the long run, this policy failed to keep family physicians in the system.

In the following, I will compare two family physicians: Elif and Ayben. Elif decided to work in a FHC for its payment while she was escaping from the workload of the CHC. In the second case, Ayben resigned from a FHC and continued to her career in the CHC because of the dissatisfaction of the conditions.

3.3.3.1. Elif's Case

Elif is a two-month family physician in a lower class neighborhood with a registered population of about 4.000. She shares the type-D FHC with two other family physicians. The day I interviewed her, she accepted more than 80 patients. She had graduated in 2009 and she had worked in Health Centers for a year. When Istanbul began to implement Family Medicine, she was strongly against the FMI and rejected working in FHCs, and, instead of working in an FHC, she worked at an Emergency Room and then at the CHC as a manager. Her reasons for

not working in FHCs are related with seeing no future for FMI, being unable to choose FHC she wants and the privatization attempt of the new program. The ones with higher service score have a chance to choose the FHC in any location but doctors with a lower service score, like her, do not have many alternatives. According to Elif's observation, the ones with higher service scores usually prefer to work in the FHCs which are transformed from the old Health Centers. Also, she thought that she could not improve her medical knowledge in FHCs. However, she changed her mind after all and she explained her choice by making a comparison between working in Emergency Room, CHC, and FHC in terms of workload:

> Let me make a comparison, I used to work much more both in a Health Center and in an Emergency and I got half the salary, even less. When I'm an administrator at Community Health, I had more mental work, more responsibility but I still got half the salary. Here the work got halved compared to health center and the salary got doubled. Actually it's more intense here but I'm speaking in terms of the average, compared to other places. [18]

Approximately 80 patients per day for her standards is a very good number although she complains about not being able to allocate time for preventive medicine for her registered population. In the Emergency Room, she was dealing with more than 200-250 patients and in the CHCs, she was responsible for more than 20 FHCs and their family physicians. FHC seems to be the best option in these three working environments in her opinion because of its payment. She "ran away from the CHC to FHC."

3.3.3.2. Ayben's Case

Ayben graduated in 2007, and until 2010 she worked in many healthcare departments from the hospital to the tuberculosis dispensary. When there was an open vacancy in a neighborhood FHC where she could apply, she applied and moved here to work as a family

physician in 2010. She had a registered population of approximately 4.000 and she had lots of clinic hours every day. When I interviewed Ayben, it was her last week in the FHC. Although she enjoys working as a doctor, she resigned from her job and she is going to start to work at CHC where her personnel cadre is. Thus she will not be able to perform her profession as she wants in the CHC. She did not pay any rent to FHCs and therefore, she did not share money from her current expenditure payment for rent thus, increasing her salary in total. She was earning about 8.000 TL but she said that she could not do it anymore. Repetitive and heavy workload, managerial duties and its effect on the relationship with her patients are her reasons for resigning:

> I resigned. I won't see patients for a while. Because I am disheartened from the job and I cannot tolerate people. I cannot listen to my patients like in the old days. [19]

> Out of the expenses, I have 8.000 TL. Even if 8.000 TL is left, I give them 8.000 TL and feel relaxed. I do not want to do this job for 8.000 TL. Because every month, you have problems and you are distressed. […] The pay is great but what we do is beyond work, it's not being a doctor. I mean if you give eight thousand liras to a teacher and let him/her sit beside me for a year s/he will learn what I do and can easily do it. There are no cases, no patients; we keep seeing the same stuff. It's blind. But the pay is good. But I'm so unhappy that I'd rather go somewhere else and get 5 thousand liras salary instead of 8 thousand, I'm unsatisfied professionally but this is the case. [20]

To create demand for FMI, salaries are made higher. The adaptability to the hybridization of the management and the profession differs from one family physician to another. In Elif's and Ayben's cases, one of the major differences between the two is the managerial experience. Elif is familiar with the management issues since she has experience in a CHC. Therefore, she is able to adapt to the system. During the interview, Elif did not complain

about the managerial part of the job. In contrast, she was fine with giving her own decisions to the two other family physicians in her FHC for the management. However, management and the entrepreneurial values in the FHC were quite new for Ayben and it becomes unbearable when they are combined with the workload in consultations. I think that the lack of education or specialized training for management has also negatively affected her experience as a family physician. As a result, her story in the FHC results in distress and resignment.

3.3.4. The Use of the Budget: The Complexity of the Management in the FHC

I will examine how the budget is used for the expenses of the FHCs. It will be examined by relying on two different choices for spending money for family physicians. As mentioned above, depending on the location of the FHC's building the monthly cost might be low, leaving extra money to the physicians. But what if the costs are decreased intentionally? To answer this question, I will focus on Hakan's and Bilge's examples to show how the budget is used when it is left to family physicians' hands.

3.3.4.1. Hakan's Case

Hakan works in a slum. His FHC is tidy but does not have sunlight in the waiting room. It creates a dark atmosphere[29]. Hakan is very talkative and self-confident. When he started to work in this FHC, the category of the FHC was class D. Later, he and his co-workers upgraded their FHC to the category B by meeting requirements. He said that his motivation for upgrading the category is to take more current expenditure payment, which means, *for him*, his salary. However, the entire current expenditure does not go to the FHC's expenses. According to him, it is the hush-money:

[29] This is not the only FHC without sunlight in the waiting room. Whether it is a previously assigned/designed building for specifically primary healthcare service or Sanal FHC, this is the general problem of the FHCs. In some of the FHCs with the same problem, they can provide a lighting system. However, at least during my field observations, I have seen few examples.

> The money for the registered population is around 5 thousand lira, depending on the number of the population. Additionally, approximately 4 thousand lira is given for expenses. This current expenditure causes higher salaries. It seems like a high salary but everybody knows, no one suffers for 5 thousand liras. [21]

> Well, the state knows that when it puts a doctor in this place [FHC], it cannot make him/her work. The state says 'I give you 9 thousand lira and do whatever you want.' This place can also be run with 16 thousand liras but we run the FHC with 4 thousand liras, but can it be possible? It cannot. The state is aware of the situation. State knows that 4 thousand liras are not paid for the expenses. [22]

According to him, no one can work under these circumstances, given workload and the impositions of the performance system. Therefore, as an eye washing strategy, the state gives higher 'salaries' to family physicians.

Although Hakan has a chance to improve the FHC's conditions, he wants to keep the money for his investments or joy and sees the two different payments as total salary. This kind of perception is highly criticized by Bilge who works in better medical conditions than Hakan.

3.3.4.2.Bilge's Case

Bilge is a family medicine specialist with 20 years of experience in medicine. As mentioned before, she had managerial experience in the CHC for four years and then she started to work as a family physician in a lower-middle class neighborhood three months ago since she wanted to be out in the field practicing medicine.

Her FHC is run by three family physicians and it is category is B. When I entered the FHC where she works, the first thing you observe is the smell of cleanliness. Everything is well decorated and compatible with each other. It is clearl that family physicians who work there pay attention to the FHC. Bilge sees her workspace as a part of her living area and uses better

equipment and materials to create a cleaner, hygienic, well-decorated environment in the FHC. She says:

> I am doing everything with a great deal of satisfaction but there are family physicians that see their current expenditure payments as their salaries. Whenever they pay for expenses, they think that the spending is from their salaries, their pockets. Then it becomes a nuisance for them whereas they are spending the money from the current expenditure payment given by the state. [23]

The separation between the salary and the current expenditure payment for her is clear. However, the use of the current expenditure payment totally depends on the personal choices of family physicians. Like Hakan, there are family physicians that prefer to meet the minimum standards of the FHC and do not pay attention to other things. This situation is consolidated by the supervisors as they do not check the cleanliness, the cleaning materials, hygiene or the decoration:

> We had an inspection today. During the inspection, they do not look at the cleanliness. It has to be checked but they do not. For instance, they are checking whether you have the pediatric sphygmomanometer, adult sphygmomanometer, heating system or the air conditioner or not. In short, they do not actually look at the decoration. The material used here is the same material we use in our homes, since we spent a lot of time in here. It is not the same in every FHC. We have coworkers who bring their toilet paper with them to work and bring it back to his home after work. This system is completely left to the people's initiatives. We are inspected as I said but it is insufficient. [24]

Since she worked in the CHC and was responsible from more or less 30 FHCs and more than 100 family physicians, she came across cases which were investigated by CHCs. As an

example, she mentions that one family physician is complained about for turning off the radiator of the nurses' room so as not to pay higher bills.

The state's attempts to reduce public expenditure by giving family physicians current expenditure payments in the primary healthcare services has resulted in different practices in the field.

One can argue that the current FMI regulation uses current expenditure payments as hush-money, and Hakan uses the payment as a personal investment rather than proving better conditions for his working area. The current expenditure payment reveals family physicians' characteristics towards the FHCs. FHCs have become visual representations of family physicians' personal choices such as decoration and hygiene. In the previous system, the state was furnishing and providing the necessary equipment and Health Centers were standardized, ordinary, average and the expectation was low from both patients and the healthcare providers. This part has aimed to exemplify the subjective behaviors involved in using the current expenditure payments from two opposite characters in the FMI.

3.4. Conclusion: Do We Ever Talk About Public Health?

Since 1970's, many countries, especially England, have been experiencing managerialism in healthcare services. Turkey did not adopt managerialism in those years. Although there were intentions and some infrastructural changes, changes were limited. The entrance of the entrepreneurial logic in the healthcare started with JDP. According to Günal (2008), JDP's "determinate attitude in changing the system" has worked to catch up the other countries where the managerialist trends have been applied for more than 20 years (Günal, 2008, p. 394).

Under these circumstances, family physicians in Istanbul have been trying to use "managerial symbols and language" in the FHCs since 2010 (Gabe, Bury, & Elston, 2009, p.

212). Governmental policies on healthcare services have a direct impact on family physicians' experience in family medicine practice. The privatization efforts of the government in the primary healthcare services have been constantly reorganizing themselves depending on the needs of the field. However, as Aslı[30] claims, the FMI has turned into a *ragbag* for the effort to meet the requirements of the system. As a result, lack of standard procedures has created diversified experiences for each family physician.

Until this point, I examined and explored the managerial experience of the family physicians by relying on the single and comparative cases. What is important in this chapter is that everything that constitutes the managerial experience is intricately related. For example, analyzing the managerial experience only through the spatial differences is not enough to understand. Financial concerns, personal choices/characteristics, relationship with partners and medical staff in FHCs, and spatial differences all come together and bring about the managerial experience and shape/are shaped by the neoliberal transformation of the healthcare system.

Therefore, it cannot be said that Bilge is satisfied with the system just because she has good relations with her coworkers. At the same time, her previous knowledge coming from the managerial experience in CHC has eased her adaptation to the FMI. Coşkun's case also cannot be understood without seeing the problems in the functioning of law, policy implementations on working conditions or expectations of the family physicians from the FMI. From this perspective, most of the family physicians are left alone by the state in a system that operates in the logic of '*kervan yolda düzülür*' (One makes up as s/he goes along).

The interview with Coşkun took more than two hours and at some point in the interview, he stopped and said:

[30] Aslı works in an upper-middle class neighborhood and provides health services to the rich and famous people. Therefore she faces with difficulties for reaching her patients to conduct her medical expertise. In the next chapter, her case will be elaborated.

> Look, do we talk about society? Do we ever talk about public health? No, we do not. What do we talk about? We talk about money. We talk about the cost. We talk about how we can handle it (referring the financial issues). We talk about how we can get things cheaper. We do not talk about how we can provide better health services to public or we do not talk about how we can improve the service standards. A family physician talks about how he can find a place at a cheap price. Is it the duty of a doctor? [25]

This is where the system has collapsed for some family physicians. The managerial experience is an area of continuous confrontation with state, partners, and medical staff and as a result, they learn what they should do while performing family medicine. In the next chapter, I will scrutinize how family physicians think about performing medicine under the HTP and what kind of encounters they have been experiencing in the doctor-patient relationship in the FHCs.

CHAPTER 4

4. Family Physicians as Medical Experts and Their Perception towards Doctor-Patient Relationship

In the previous chapter, I examined the Justice and Development Party's (JDP) neoliberal policies and New Public Management (NPM) logic in the primary healthcare services with a focus on new managerial responsibilities. Now, I will look at both neoliberal and populist policies of the JDP and how these policies affect the medical practice of family physicians and, specifically, doctor-patient relationships in the family medicine context.

I will begin with examining the causes of the changing patterns in doctor-patient relationships with a focus on the loss of autonomy of the family physicians. Then, I will move on to the satisfaction of family physicians by giving examples from their experiences and interrogate what determines their satisfaction or dissatisfaction from their medical expertise. In the third part, I will illustrate the relationships of family physicians and their registered population from their interviews and the stories they shared.

It is argued that the JDP's electoral victory is closely related to the implementation of the Health Transformation Program (HTP) (Yılmaz, 2014, p. 158). A chart prepared by the Turkish Statistical Institute displays the satisfaction from public services in general between 2003 and 2016 (TUIK, 2017). The rate of satisfaction with the healthcare services is 39.5 before the establishment of HTP and it rapidly increases to 75.4 in 2016. Increasing rates of satisfaction with the healthcare services has mainly been due to the fact that the HTP has facilitated poor people's access to healthcare services.

Previously the health insurance system was organized according to the employment status of the citizens, and, as a result, unemployed citizens or the ones who work in the informal economy did not have access to the healthcare system (Yoltar, 2009, p. 769). The expansion of

public health insurance to all citizens and easing access to healthcare services during JDP's period (Yılmaz, 2014, p. 164) earned the JDP electoral victories and a high level of satisfaction from the healthcare services.

The rate of satisfaction from Family Health Centers (FHC) is much higher than that of health services in general. According to the survey conducted by the Ministry of Health: ‘'the satisfaction with health centers was found to be 75 % in 2008 while the satisfaction with family medicine was found to be 90 % in 2011" (Akdağ, 2012, p. 112).

Another statistic is about the number of visits to FHCs. In 2002, before the implementation of Family Medicine, the number of visits to Health Centers was 68,103,517 and then it increases to 208,538,951 in 2015 (Köse, 2016, p. 132). Thus, there is an increased demand for primary healthcare services. In the following, I try to understand the effects of this increased demand on medical practice and doctor-patient relationship in FHCs. I argue that whereas JDP focuses on citizens’ satisfaction, it ignores health providers’ satisfaction. As a result of the dissatisfaction within the new system, doctors started to complain about the factors I will explain in the following part: *loss of autonomy* and *the rise of consumerist behavior.* The chapter begins with the general discussion on deprofessionalization and neoliberal governmentality within the context of Turkey. In the second part, I will provide the outcomes of the fieldwork by focusing on: (1) satisfaction of Family Physicians from their experience and (2) doctor-patient relationship in the FHCs.

4.1. Deprofessionalization of Medical Experts

In the previous chapter, I argue that family physicians turn into managers as a result of the quasi-market tendency of the health reform in FHCs. The reason for dividing the family physicians’ new identity into managers and professionals, rather than seeing them as one entity, is to explain the ongoing transformation of family physicians in an easier manner. For instance,

Halford and Leonard (cited in Olssen, Codd, & O'Neill, 2004, p. 186) "see managerial reforms as 'restructuring' the identity of professionals." The job description of family physicians as primary healthcare providers has changed not only because of their newly emerged managerial positions but also because of the loss of autonomy with the monitoring of their medical expertise via their performance system and transformation of patients into clients. As a result, the title 'professional' is challenged by the term: "deprofessionalization *in the sense* that autonomy and trust are replaced with new additional forms of accountability and control"(Olssen, Codd, & O'Neill, 2004, p. 186). In this section, I will look at the latter part of the discussion and focus on how we can think about the family physicians as *professionals* in the context of deprofessionalization.

Profession is defined as "an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service'' (Freidson, 1994, p.10). Professionals who practice a specific profession like doctors in this context, have "a privileged position and status in society and their activities have typically been protected or sanctioned by the state" (McKinlay and Marceau, 2002, p. 381). This protected position of the professions gives them an autonomous and powerful position. However, since the late 20th century, there is a visible decline of the medical profession (Haug, 1975; McKinlay & Marceau, 2002; Reich, 2012). The interests of state began to change, and "the state shifted its primary allegiance from the profession's interests to often conflicting private interests"(McKinlay & Marceau, 2002, p. 383). Deprofessionalization challenged the professions' autonomous, privileged, powerful, and prestigious position in the society (Haug, 1975, p. 201).

According to McKinlay and Marceau (2002), causes for the loss of autonomy can be categorized under eight factors:

> Major extrinsic factors are (a) the changing nature of the state and loss of its partisan support for doctoring; (b) the bureaucratization (corporatization) of doctoring; (c) the emerging competitive threat from other health care workers; (d) the consequences of globalization and the information revolution; (e) the epidemiologic transition and changes in public conceptions of the body; and (f) changes in the doctor-patient relationship and the erosion of patient trust. Major intrinsic factors are (g) the weakening of physicians' or market position through oversupply; and (h) the fragmentation of the physicians' union (the American Medical Association, AMA) (McKinlay & Marceau, 2002, p. 382)

I used these factors as points of reference in my analysis of how family physicians in particular regard the neoliberal transformation of Turkey. McKinlay and Marceau's case is peculiar to the US and Turkey was not under this kind of transformation in those years. Therefore, the disintegration of the interests of the state and the doctors started later in Turkey when it is compared to the US. Since the establishment of the HTP, Turkey has become familiar with these factors. Ulutaş categorizes the changes after the HTP and makes a connection between the loss of autonomy and the prestigious position of doctors with the neoliberal transformation of healthcare services:

> […] recently with practices such as reinstallation of the mandatory service law, TQM (total quality management), performance, finance experience; and developments such as the intensification of the technological and bureaucratic control, increase in the number of physicians and the competition thereof, the prominence of patient satisfaction, increased number of private health institutions and the prevalence of the insecurity in public employment have shaken the autonomy of the physicians and their privileged status, in Turkey as well as around the world. (Ulutaş, 2011, p.223)

The atmosphere in FHCs, factors which I can analyze relying on data expored in earlier chapters, are related with *labor control of the family physicians* and *change in doctor-patient relationship*. For the first one, I will benefit from Foucault's *Governmentality*[31] and for the latter one, I will consider the impact of the populist agenda of the JDP.

4.1.1. Labor Control over the Family Physicians and Neoliberal Governmentality

As I discussed, these market-driven transformations in healthcare services are closely related with the neoliberal policies of the JDP. Foucault sees neoliberalism "not only as an institution building practice, but also as governmentality or as a post liberal art of government"(Türem, 2016, p. 40) and he also sees neoliberalism as it "involves attempts to re-organize society according to the enterprise form"(Brady, 2014, p. 24). While the market mechanisms are strengthened by the state, the state has also been becoming more powerful in terms of control and regulation (Olssen et al., 2004, p. 172).

On the one hand, as part of a NPM, there is autonomy in managerial responsibilities in FHCs (see Chapter 3) for family physicians; but on the other hand, there is loss of autonomy in the practice of their expertise. One of the reasons for the loss of autonomy is that family physicians are assessed by a performance system. Neoliberal governance over medical expertise has become visible in the primary healthcare services with the performance system.[32] Therefore, professional labor turned into an accountable form, which eases the control of the government. A performance system is created to control and monitor the workflow of the primary healthcare providers while also aiming to discipline them. The surveillance and its

[31] Government from a Foucauldian approach is defined as ''a form of activity aiming to shape, guide or affect the conduct of some person or persons''(Gordon, 1991, p. 2) and governmentality is related with the question of ''how to govern'' (Gordon, 1991, p. 7).

[32] Although the performance system is not only applied in FHCs, since the focus of this thesis deals with the family physicians' experience, I will examine the performance system as a part of a neoliberal governance strategy of the JDP through the family physicians' experiences.

ambiguity in practice[33] comes up in the interviews with the family as a threat from the government, job insecurity, and dissatisfaction/distress; I will provide the related examples in this chapter.

Neoliberal governmentality is not limited to these elements such as control and surveillance over primary healthcare providers in a negative way, but it includes where it connects with the deprofessionalization is the performance system. Therefore, I introduced neoliberal governmentality here. Now, I will discuss the reasons of the changes of the doctor-patient relationship in the healthcare services in Turkey.

4.1.2. Changes in Doctor-Patient Relationship

The traditional form of the doctor-patient relationship includes a paternalist manner of behavior. In this form, the roles are characterized according to activity (doctor as father/parent) and passivity (patient as an infant) during the consultation in the examination room (Gabe et al., 2009, p. 97). The professional authority is coming from the "monopolization of knowledge" (Haug, 1975, p. 198) and it requires "long formal training" coming with "high status and high rewards" (Gabe et al., 2009, p. 163).

However, the monopoly of the expert knowledge has been reduced from the hands of the doctors in the last decades, and medical knowledge is spread from different portals such as social media, health programs on TV, and informative health programs in the hospitals. As opposed to the traditional relationship, new doctor-patient relationships including the active participation of the patient in the decision-making process during a consultation and being able to reject the treatment suggested (Gabe et al., 2009). After the 1980's, in line with the rise of

[33] Foucault states "surveillance is permanent in its effect, even if it is discontinuous in its action"(Foucault, 1997, p. 201)

consumerist logic, it is also argued that the doctor-patient relationship has turned into a client-provider encounter (McKinlay & Marceau, 2002, p. 403).

Strategies of market-based practices are now experienced in the public organizations as a part of the HTP. In Turkey, "consumer choice and customer satisfaction" as being a required component of NPM (Ward, 2011, p. 208) manifested itself after the launch of HTP in Turkey. Patients[34] are no longer passive recipients of the healthcare services, but rather they are becoming more demanding and being aware of their rights as patients (Ulutaş, 2011).

More active participation in the decision-making process is also related to the empowerment of patients. The WHO describes empowerment as "a process through which people gain greater control over decisions and actions affecting their health" (*Health Promotion Glossary*, 1998, p. 3). It is important to ask questions like "what does gaining greater control means in a society with low health literacy rate?" or "what happens when health policies are used for populist purposes to increase the satisfaction of the citizens?" Ideally, there must be specific requirements and educational training if the involvement of the patients in the medical process is supported by the government. According to the European Health Parliaments study *Patient Empowerment and Centredness*, two of the features for being empowered patients are "having the necessary knowledge, skills, attitudes, and self-awareness about their condition to understand their lifestyle and treatment options and make informed choices about their health" and "having the capacity to become 'co-managers' of their condition in partnership with healthcare professionals" (Bonsignore et al., p. 2).

Not only did the health reform affect the doctor-patient relationship, but there is also the impact of the JDP's populist policies on the 'empowerment of patients', against which we

[34] It must be noted that I interviewed family physicians and it prevents me from seeing patients' perspectives about the behaviors of family physicians during consultation. Therefore, I cannot provide information about what happens in the examination room between the doctor and patient. What I am doing here is showing how family physicians feel/express/explain themselves and their positions as family physicians.

need to remain critical; according to my interviews, patients are not only empowered but also provoked (*kışkırtılmış*) against doctors.

The rapid and top-down change in the healthcare sector as a result of neoliberal policies was also shaped by the populist policies. The HTP was launched with the promise of citizens' satisfaction and the above-mentioned Turkish Statistics Institute's statistics confirms that the level of satisfaction increased after its implementation. In this part, I will look at how the satisfaction of patients is acquired and what kind of factors are ignored and/or undermined for the sake of patients' satisfaction, which often resulted for electoral victory and continuation of power for the JDP.

In the FMI[35], the doctor-patient relationship is neither paternalistic behavior-based nor negotiation-based which means that a patient is also active in the decision making process during the consultation and, if necessary, in the treatment process. Can, as I mentioned before, is a family medicine specialist and provides service for a mostly elderly and non-Muslim population in an upper-class neighborhood. When I asked him what he thinks about the patients' rights, he argues that patients turn into demanding citizens without being aware of their rights, and he thinks that they feel like they can go wherever they want to get healthcare service although it shouldn't be like the way it is practiced now:

> Patients don't know their rights. They are not given an instruction on the patients' rights either. They are also provoked against doctors to neglect their rights. So it's all about making the patient happy. The current policy is to keep the patient happy no matter where s/he refers to. As long as his/her business is handled. There is no such welfare system anywhere in the world. There is no such medical practice either but such a mass of patients are now created. [...] A patient goes to the Emergency when s/he has a runny

[35] Cases differ in different healthcare services such as in Emergency Room or pin private hospital. This case discussed around the FMI.

nose, why? I can't go to the doctor in the morning so I will go to the emergency. [...] People with runny noses going to emergency because they can't go to the doctor in the morning and they feel entitled to do so and the current policies support this. [26]

In normal circumstances, when a citizen gets ill, the first step should be the FHCs. However, in this case, a significant portion of citizens may prefer to go to Emergency Rooms. Can explains the reason for using emergency rooms for consultation, they cannot spare time for consultation during the working hours. Patients use Emergency Rooms after work. According to the president of Emergency Medicine Association of Turkey Prof. Dr. Yıldıray Çete[36], the number of visits to Emergency Rooms is more than 110 million in 2016. He compares these numbers with England: "For instance, the number of visits in England with 65 million citizens is only 23 million. We have 110 million. This horrible difference creates exhaustion among emergency healthcare staff.'' After he linked patients' behavior and the populist policies which promote patients' rights, I asked Can to compare the situation with the previous system and he said:

[...] it was much better because the patients back then were not encouraged to violate the rights and against those they have rights. People who do these, are ignorant people. Educated people like yourself would not go to the emergency when they have a runny nose. Ignorant people are encouraged to do so. Whoever is responsible for this I don't see them as humans. Those who encourage are responsible for this. They are the people who give the right to do so. That person should be told that s/he has no right to go to the emergency, that they will be rejected if they do so and that the medical crew has the right to reject them, they should learn this. This is the patient education. Patient

[36] http://www.medimagazin.com.tr/guncel/genel/tr-acil-basvurulari-nufusu-da-gecti-11-681-73498.html

education is not telling the patients to go check their sugar levels if they have dry mouth. [27]

While the government continues to promote patients' rights and satisfaction, it does not pay attention to health literacy. According to Turkey's Health Literacy survey (2014), 64.6% of the population is insufficient (*yetersiz*) (24.5%) or problematic (*sorunlu*) (40.1%) in terms of health literacy. As a result of lack of knowledge on their rights, it causes many problems in the healthcare services. For instance, the above mentioned statistics about the overuse/misuse of the primary healthcare services, as Can mentions, is also related to the low health literacy rate of the citizens according to the findings (Tanrıöver, Yıldırım, Ready, Çakır, & Akalın, 2014).

Two of the important changes are provoked against doctors/empowered patients and misusing/overusing of the healthcare facilities as a consequence of policies for healthcare while there is not enough focus or attempt on health literacy. Another consequence of the policies of government is the increased number of acts of violence against healthcare staff.

In 2012, ALO 113-Beyaz Kod (White Code) has started to accept the complaints of the healthcare staff who are subjected to physical or verbal violence. Previous Minister of Health Mehmet Müezzinoğlu declared that the number of application to this service was 20,159 between the years of 2012 and 2014.[37] Later, Ministry of Health reported the number of applications as 25,443 between January 2015 and April 2017 (*Türk Tabipler Birliği Çalışma Raporu 2016-2017(Turkish Medical Association Working Report 2016-2017)*, 2017, pp. 14-15). The applications to ALO113-Beyaz Kod[38] increased approximately 90%. Bilge as mentioned in the previous chapter, is a family medicine specialist with more than 20 years of

[37] https://www.haberler.com/bakan-muezzinoglu-2-yilda-20-bin-159-saglikciya-6086337-haberi/

[38] Further research is required for ALO 113. The complaints can be analyzed quantitatively to look at the perception of violence against doctors among doctors. As far as I observed, there is a changing behavior and perception to violence including fear and anxiety towards doctors in the last years with the HTP, and it needs more attention to understand the changing patterns of the perception of violence of doctors.

experience and she works in a lower-middle class neighborhood. When I asked for comparison of violence against doctors in Health Centers and FHCs, she made a connection between the electoral victory of the JDP and violence against doctors:

> In every section of the society, violence is increasing which is the case in health [services] as well. Government got a lot of votes for health [care system]. An important factor in rising votes is health. The patients come to the doctor in a provoked state of mind. Violence in health [services] increased incredibly. [28]

There is an inverse correlation between the rights of doctors and patients in the field: the more promotion of patients' rights means the less focus on doctors' rights, and, for instance, the TMA is opposed to this ongoing process in health: "[…] the TMA rejects the bifurcation of 'the right to health' between the rights of medical doctors and the rights of citizens. Instead, it aims to unify the struggles of medical doctors' rights and the citizens' rights to health care" (Yılmaz, 2014, p. 181).

The government does not prepare citizens for using healthcare services as much as it promotes patient's satisfaction and pays less attention to doctors' rights. Populist policies such as mandatory shift practice and 184 SABIM, which are examined in the next parts, encouraged misinformed and ill-informed patients to demand primary health care service whenever and wherever they want. As far as it shows that there is a correlation between the emphasis on the rights of patients and doctors' and satisfaction of them. It means that HTP ignores the healthcare providers' morale and work satisfaction.

The following parts of the chapter will look at these factors which affect doctors' satisfaction/ability to work and the patients' satisfaction during the health service and encounters with physicians in the FHCs through the lenses of family physicians.

4.2. Satisfaction of Family Physicians from Their Medical Expertise: *Trying to Cure Malaria Constantly without Draining the Swamp*

This thesis aims to understand the FMI through the family physicians' perspective. The third chapter discussed the managerial turn in the primary healthcare setting and how family physicians are adapted/reacting to the new application as new managers. In this part, I investigate these doctors' job dis/satisfaction and how medical expertise was reorganized after the HTP. I will further analyze the questions of (1) "what do family physicians do except their managerial duties during working hours?" and (2) "what kind of experiences are gathered by family physicians and how do they think about their working questions?"

4.2.1. Daily Routine of Consultations in Family Health Centers

Mert, who works in an upper-class neighborhood, tells a story during the interview. According to the story, a man asked family physicians about the daily visit numbers somewhere in America. One says, 20 patients. He says 'great' to him. Another one says, 25 patients. And he says 'ah, it is okay, not that bad'. The third one says 30. He says that 'you don't see any patients, a doctor cannot see 30 patients in one day. The maximum number is 15-20, you cannot have 30 patients'. For the one who tells the story, 30 consultations per day creates only quantitative achievement and it does not provide proper consultation with family physicians.

The structure of the regular consultation consist of "opening, presenting complaints, examination, diagnosis, treatment, closing" (Heritage & Maynard, 2006, p. 14), and each step requires attention for understanding the patient's problem and it cannot be shortened to a few minutes. After the story, Mert adds that "here, a physician who has it easy gets 60 or 50 patients a day." This explains the regular workload of most of the FHCs, especially in the poor neighborhoods in Istanbul. The other factors that influence the number of patients include the location of FHCs, registered populations' patterns for utilizing from FHCs, the number of the

population who are considered as performance target, and changing expectations of patients in practice. In the following I will discuss *how* doctors experience their encounters with patients.

4.2.1.1. Workload and Preventive Healthcare Services

Family physicians are responsible for patient-specific preventive healthcare services besides diagnostic, curative, rehabilitative, and counseling services (Öcek, Çiçeklioğlu, Yücel, & Özdemir, 2014, p. 3). Although the system is reorganized to provide preventive healthcare services, the FMI, under the influence of neoliberal and populist policies which prioritize the citizens' satisfaction, fails to provide preventive healthcare. Family physicians cannot allocate time for preventive medicine because of the workload due to follow-ups and daily curative services. For instance, Elif complains about finding no time for preventive medicine. She sees approximately 80 patients per day and her registered population is mixed with middle and lower class citizens. Even if she wants to spare time for pregnant women in her population, the clinic work prevents her from giving education to pregnant women. As a result, problems may arise with the patients in the waiting room:

> The essential purpose is preventive medicine. We cannot do it, we usually have to handle it with prescriptions. Patients cause problems in that sense, I mean those waiting outside. We ultimately have to follow the patients, who is sick who is expecting, who is a baby etc. Tension may rise outside. [29]

This workload and problems arising from the complaints of the waiting patients are common characteristics for family physicians, especially for the ones who work in a lower class neighborhood with a heavy workload. As opposed to Elif's example, Murat sees 40 patients in his FHCs and his population consists of upper-middle class, educated, and elderly population. He has more than 30 years of experience in medicine, and therefore he has a chance to select the FHC he wants to work in. A longer length of service means more chance to work in a better

environment. When I asked about the working conditions and the number of daily visits, he says the average number is 40-45. He continues by making a comparison with the other districts: "Our FHC has low numbers but, for instance, go to Esenler, there are family physicians that see 80-100 patients per day" [30]. In addition to the low visiting numbers, most of his pregnant women and the parents of his registered children do not prefer to utilize the primary health care services. Rather, they mostly prefer private hospitals or clinics. Murat does not have spare time for preventive healthcare as much as Elif does. It means that location and the population structure together affect the workload intensity in the FHCs.

In terms of workload, family physicians like Murat who chooses relatively comfortable FHCs are comparatively more satisfied with their jobs. However, in terms of the encounters, both sides have difficulties with patients.

Different from other examples, Aslı is able to spare time for her population for preventive healthcare purposes but she has a different reason for not paying attention to preventive services: she is also busy handling the mandatory shifts problem in FHCs. Aslı started to work in the family medicine system in 2010 in Istanbul, and she is an active member of the TMA in Istanbul. Her FHC is located in an upper-middle class neighborhood and her population consists of elderly people and she mostly deals with patients with chronic diseases. She sees 30-40 patients per day. She also sees a few pregnant women and children regularly. The number for infant and pregnant women she is responsible for is approximately 15. The number is much better compared to other FHCs in Istanbul. When I asked about her working conditions, she answered this question without relying her own experience[39]:

> Training is very important. When a patient comes here, I should be able to train the patient. If a patient is a woman, I should refer her to mammography and smear test; if

[39] As Aslı said, she is an active member of TMA and she is aware of the general problems of FMI. Thus, her narrative is also shaped by the other family physicians' experiences.

she is a woman with children, she should know what to do when her child has diarrhea. We do as much as we can do but time is insufficient because there is an incredible clinic work. They force us to provide curative services at most. You should accept any patients. This is how the system works, everyone works for curative services only. [31]

Then she explains how things get worse when a family physician has to be quick to meet the demand:

We get shut in this room. Patients come and go and you examine all of them, you may not have time for each patient. It's like *trying to cure malaria constantly without draining the swamp*. [32]

The daily routine of most of the family physicians, especially in the poor neighborhood with high numbers of performance target population, consists of an intense workload, which includes constant encounters with the patients. At the end, there is not enough time left for health education for their population. They mostly focus on preventive and curative healthcare services and days pass by like this. It also affects their satisfaction with their job. Although there are positive outcomes for the vaccination and follow-up rates[40], Aslı's example of 'trying to cure malaria without draining the swamp' is a metaphor which points to the government's populist policies. This implementation for satisfying the patients only helps to *save the day*. However, it does not provide an efficient permanent solution for healthcare services. This leads to increasing dissatisfaction amongst family physicians about their job.

Another triggering and influential factor that determines the level of satisfaction and distress and prevents working more efficiently is the mandatory shift practice.

[40] See page 22.

4.2.1.2. Mandatory Shift Practice

In the previous chapter, I shortly introduced the shift procedure. In 2015, shifts became mandatory in FHCs. However, as a result of protests from family physicians, the law on mandatory shifts was repealed in 2016. Within this time period, most of the family physicians refused to participate to these shifts. They faced mobbing of the directors and threats of penalties, including the termination of their contracts. They received official letters that asked for their defense for their non-participation in mandatory shifts.

Aslı was against the shift practice since, for her, it is not a requirement for family medicine[41]. Thus, she did not attend the Saturday shifts and as a consequence, she was asked to give a defense statement. As I said before, she actually had spare time for her population. However, she was distressed and could not concentrate on her work: "what we are focusing on now is whether we will take shifts or not, we are stuck on that issue. For instance, we can provide additional healthcare, but we can't even do that as we are so busy with other stuff (referring, writing defenseses and the pressure from shifts)'' [33]. According to her[42], these practices did not serve citizens because they blocked the routine of the family medicine practice. In the previous chapter, Coşkun complains about not being able to talk about public health problems because of the managerial turn in the FHCs, and, in this case, Aslı complains about the populist policies[43] and the threats coming from the directors, which prevent her from giving attention to the medical obligations. Aslı is not the only one who suffers from the shift practice. Can, who thinks that FHCs are not equipped to provide healthcare services on Saturdays,

[41] In the previous chapter, I discussed the shift practice under "The Effect of Mandatory Shift Practice on Unionization and Mobilization." A shift is not a requirement/duty for family physicians. It was added to the regulation later and family physicians were forced to participate in these shifts, as I explained. Therefore, she did not attend the Saturday shifts.

[42] Whenever they do not attend mandatory shifts, they collect penalty points because of the absence during the shift. They were constantly threatened that it might end with their contract termination. (http://www.radikal.com.tr/saglik/binlerce-hekim-kapi-onune-konabilir-1350412/)

[43] Aslı sees pratices like shifts as an investment for elections.

claimed that shift practice spoiled the working condition when we were discussing the effect of government's policies on family medicine implementation:

> I mean, the working conditions and then the extra work put on the family physicians deteriorate these conditions. The latest is the Saturday shifts. It is completely a repressive administration. It's against the decisions of International Labor Organization and ECHR, they are forcing us to work more than 8 hours. This is what distresses us the most. We refuse to stay for the shifts, we are currently resisting against that. [34]

Like Aslı, Can also thinks that shift practice is not the component of FMI, but is part the populist policy. Mandatory shifts are used as a tool to show citizens that they can get healthcare services whenever they want. As opposed to the pro-patient purpose of the practice, for Murat who attended Saturday shifts for a couple of weeks, citizens do not have this kind of demand from family physicians:

> The patient has no such demand, we have been open on Sundays a couple of times for a while and not even one patient turned up. Because the patients here have no such expectation. They are used to it anyway, if you have an emergency you go to the emergency. There is populism here, showing off to people, *look I brought doctors to your feet on Saturday*. [35]

This quote exemplifies the failure of the correspondence of population needs and the populist agenda in the primary healthcare services. On the one hand, family physicians are forced to take shifts on Saturdays and on the other hand, there are empty FHCs without patients on Saturdays.

In the next part, I will discuss the familiarity of the family physicians with their registered population as an outcome of the FMI. I argue that this familiarity creates a positive impact upon family physicians.

4.2.2. Familiarity with the Population

In the previous primary healthcare services, patients were able to get service from any general practitioner in any Health Center. Today, citizens[44] are assigned to one family physician. Patients are allowed to change their family physicians after six months. Family physicians are also able to accept/reject new patients. Sometimes they do not prefer to accept more patients because of having so many patients on their list.

Family physicians that have work experience in Health Centers are able to compare the encounters with patients. Patients start to visit the same family physician and family physicians, in return, start to provide healthcare to the same citizens. This continuity creates familiarity with the population and this familiarity, in turn, eases the control of patients' health conditions. Serkan, as a family physician with years of experience in Health Centers, describes this change as follows:

> Patients used to come to the Health Center and whichever general practitioner was available would see him/her. Patients were not able to choose the doctor they wanted due to the line. The same patient could be examined by different general practitioners so the follow-up would not be proper, but the family physician system started such follow-up system. Now you have the chance to follow the patient, you get familiarized with the population. Those who are not satisfied can change (the physician), and the communication is much better. [36]

In the previous system people were coming and going and they may not visit the same doctor again. Long-term follow-ups were not possible in Health Centers, especially in the cities like Istanbul where the people are constantly moving. If patients did not come to the same

[44] During my fieldwork, I didn't encounter these citizens because I primarily talked to doctors in family health centers. However, according to Öcek et al's' article, significant portion of citizens are not assigned to any family physicians because of the failure of the referral chain, lack of field work, the presence of people without any record in state's census record, and mobility (Öcek et al., 2014, p. 5).

doctor, a general practitioner was not able to find him and follow their health conditions. However, with the new system, everyone has one family physician and it allows family physicians to get familiar with their registered population. When I asked Can whether he observes differences with the previous system, he also shares the same opinion with Serkan:

> Sure we observe (the change) because now each patient gets a physician and since the same patients keep coming, the patient-physician relationship can be built much easier. This wasn't possible at Health Centers. The patient would come and s/he'd be assigned to you or to another practitioner by the computer, there wasn't any special order. Therefore there wasn't a setting for a closer patient-physician relationship. [37]

Also, some doctors stated that they feel an emotional attachment to their registered population because of the ability to follow/control their health conditions. For example, Serap is a family physician who has more than thirty years of experience, and she states that:

> After we passed onto this system the most fundamental difference from Health Centers was the emotional connection. Before, we would forget about the patient once we went home. Now we have an emotional bond, when something happens, when they die, we get upset. [38]

Like the family physicians coming from the Health Centers, the younger generation of family physicians who did not experience the previous system like Elif also mentions the positive effects of the familiarity with the patients in family medicine system:

> […] the good thing about this is there are people registered under you, you only have relations with them, there is continuity, you can follow them, keep track of their health. Both from your perspective and that of the patient, it's better, trust is built and the transfer of information is sounder. It's not like one comes and goes. If you come back

and something is neglected, you can detect that in the second or third appointment, so it's better in this way. [39]

Long-term relationships between patient and doctor lead to trust and makes early diagnosis possible because of their familiarity with the medical history of the patient. Familiarity with the population creates satisfaction among the family physicians with the FMI. However, this kind of familiarity cannot be achieved because of the preferences of population for getting service, especially in the upper-middle or upper-class neighborhoods. So far, I discussed the daily and bureaucratic routines of the work from the perspective of the doctors. Now, I will more specifically look at how doctors experience daily encounters with patients in FHCs.

4.3. Doctor-Patient Relationships in the Family Health Centers

Family physicians' experience is composed of working conditions, medical and social environment, governmental policies, and lastly, the patients. Family physicians spend most of their time in FHCs with their patients. Therefore, how they construct their narratives and give information about the encounters with their patients are very important to understand the impact of the FMI on family physicians. As stated in the theoretical discussion part of the chapter, the state has taken away its support from doctors after the HTP. It resulted with less support for family physicians in the doctor-patient encounters by the state and, instead, more investment on citizens' satisfaction with healthcare services. The failure to balance the satisfaction of doctors and citizens will be discussed here.

Adnan is a family physician with more than 35 years of experience in different healthcare services, such as in Health Centers, Emergency Rooms, and 112 (Ambulance Emergency Service in Turkey). His length of service and different experience in different healthcare services in the public sector allows him to make a comparison between the previous

system and the HTP. He argues that today, doctors are less respected and open to cruel treatment by the citizens:

> I'm talking about the years '75-'76, back then medicine was a popular profession. It was more prestigious, respected and loved by the people, it was a context where people had a kinder approach to the doctors and people used to value doctors more. This is not the case anymore, unfortunately. Now, the doctors are assaulted and battered as you see on media. We can't even talk about respect anyway, if you do something other than what the people want you are exposed to all sorts of maltreatment. The administrators are not how they used to be, either; no one stands by our profession. Since it is a profession where you have such close contact with the public, even the smallest disagreements can grow into bigger incidents and they do most of the time. [40]

He complains about the loss of support from the government and/or the directors and thus, they are left alone with the patients. He thinks that it is the result of the government's policies on health and says: "Recently especially, the current government or the state mentality made things worse. It's been much worse over the last 10 years'' [41].

Many doctors I interviewed think that government policies on healthcare services affect the relationship between the doctor and patient. In the following I will discuss the three topics that regularly emerge in doctors' narratives as they talk about how government policies negatively influence patients' perception of and behavior towards doctors. These are (1) unlawful demands and unjustified requests from family physicians, (2) performance system, and (3) 184 SABIM which is a health information communication line.

4.3.1. Patients with Unlawful Demands and Unjustified Requests

As displayed in the 'Loss of Medical Autonomy' section, the effect of populist policies increased the unlawful and insistent demand from family physicians and the number of visits

to FHCs. According to family physicians I interviewed, there are two reasons behind patients' unlawful demands: (1) having access to healthcare services in any healthcare facilities and (2) the lack of health literacy of patients. These common patterns are much more visible in the middle/middle-lower class neighborhood when compared to upper/upper-middle class neighborhoods.

Can[45] complained about patients' lack of knowledge about their own rights. A few days before our interview, a person comes to his FHC and asks for a report. That person was not registered in Can's list. However, he insisted on receiving a medical report to use his medicine and proposed him to be his family physician. Can suggested that he go to a hospital for a report and refused to give a report to him. As a result, the person got angry and left the FHC:

> What we encounter most frequently here is patients, especially those who are not entitled to a service here, not knowing their rights. They don't know what they are entitled to. To give you a summary, the patient comes and asks for a medical report for his/her medicines. His family physicians can write a report, but the patient comes to me and asks for it. Where is your family physician? In Beşiktaş. *I want a report, can't you write it?* I can't, I'm not your physician. *But then why don't you become my family physician?* Why would you change your family physician just to get a single report? I tell the patient to get a report from the hospital and he gets angry at me. [42]

The first thing is that the person did not know the place he has to go for receiving a report. Secondly, even if he knew that he has to go to his family physician, he thought that he could *get lucky* in this FHC. Maybe for him, it is something that can be tried and/or demanded. Thirdly, he thought that he was able to change his family physician to receive a report. Lastly, even when Can explained the reasons why he could not get the report from him, he got angry

[45] Can is a family medicine specialist and provide services to the upper-middle class.

to Can. This demand for the report is not limited to Can's example; Bilge who works in a lower-middle class neighborhood also has had similar encounters with her patients:

> We are not obliged to give a sick report to anyone who comes here. This is what people expect. Those we don't give reports to, leaves in frustration. They have a salary cut at their place of work but seriously I don't want to write sick reports for those who are not sick because I've been working when I'm sick too. That's why we have fall outs with people. [43]

Patients who ask for reports shout at her when they do not receive one. The perception that demands are instantly met by their family physicians is the problem of family physicians in their daily encounters with patients. According to Bilge, satisfaction does not come from the quality of the service during the medical examination. What matters here is accepting the patient's request in any case. Unlike the previous examples, people can leave the FHCs with full of satisfaction:

> [...] there are people leaving with satisfaction. As I said, the expectation of the patient matters. For instance if the patient is here to get a report, your treatment or your smiling face doesn't mean a thing. If you tell the patient you'll write the report, s/he is the happiest on earth, but if you say you won't, the patient leaves the room cursing. It depends on the personality, expectation and the mood of the patient. [44]

Another request example which can be categorized as both unlawful and unjustified is the consultation demand without an identity card (ID). It is a requirement for citizens to have their ID if they want to get healthcare services from FHCs. Ayben, as introduced in the previous chapter, was a family physician in a lower class neighborhood and had heavy workload density. He had a conflict with a patient who had been coming to him for six years. Although he did not bring his ID card with him, she unwillingly examined him. She explained her reasons:

> I have a patient for six years for example, the guy shows up once a week. I know the guy, but he doesn't have his ID with him, it's an offense. But I know him, if he goes home to get his ID, it's the same ID, and it doesn't change anything. I tell him I can't examine him, he gets offended, broken hearted. Some of them get stubborn, they start a fight. Then you examine them, but you have this anxiety. If there is an inspector from the state, the guy doesn't have his ID, you're *screwed.* [45]

When the patient does not have an ID card, a family physician does not have to examine the patient. However, she uses initiative and accepts his demand. But later, it can be abused by patients as in another case Murat discusses:

> Then you're in this position, as if it's in your initiative but you choose not to do so. But legally it's wrong. Yes I can handle it using my initiative maybe, but it can put me in legal trouble first of all, and secondly it may not be ethical. It's not right for me to do it for him/her and not for others, it bothers my conscience, there are all these social phenomena but this is the general perception. [46]

Laws do not clearly define the limitations of the practice according to some of my interviewees' claims and even when they are defined well, they are not announced or taught to citizens. Doctoring is not a matter of morality and the decision cannot be left to the dilemma of using initiative or not. However in these cases, patients and family physicians are left alone in the decision-making process.

While the state discourse is based on patients' satisfaction on a theoretical level, in practice, as a consequence of populist health policies, patients are encouraged to raise their health and health-related demands from family physicians in FHCs.

There are also patients with low expectations from FHCs and thus, satisfaction is not a case for these patients. Murat, who has an upper-middle registered population, says that their expectation from the FHC is not high because they have their private doctors:

> It's because they don't get everything handled here. Almost all of them go to private pediatricians. They have OBGYN practitioners or if something happens they can go to private hospitals as they have private insurance. They only come to us to get their prescription or for minor health problems. […] They are only obliged to come here for the services that the state has to give. [47]

There is a significant portion of the population with relatively high income who does not get service from FHCs if it is not urgent or mandatory. How patients benefit from the primary healthcare services depends on their class. Until this point, I discussed the problems regarding encounters between doctors and patients mostly in the middle-class or lower-class neighborhoods. Having no expectation sometimes means refusing to get service from FHCs and it may create problems for both doctor-patient relationships and family physicians' and family medicine personnel's salaries. The next part will focus on the performance system and its consequences in the FHCs in wealthy neighborhoods.

4.3.2. Performance System and the Creation of a *Tacizkar* (Disturbing) Family Physician Image

The HTP introduced a performance system and used it in FHCs as well. Family physicians and family medicine personnel[46] are obliged to meet specific performance targets

[46] I exclude family medicine personnel's perspective from the research. Since the dynamics of family physicians as an occupation from managerial duties to professional duties are so complex, I wanted to focus solely on family physicians' experience and narratives. However, I conducted interviews with a few family medicine personnel to understand the operation of the FHCs in general for a preliminary research. In addition, during the observation part of my research, I observed that there is a room for vaccination in FHCs and, as far as I observed, in this room, family medicine personnel was spending more time with pregnant women and children. Also, Öcek et. al. (2014) included family medicine personnel in their research and one informant says: "generally, vaccinations and follow-ups are done by FHWs. As they constantly have to work in the clinic, FPs cannot devote time to these services.

regarding maternal and child health for their registered population including immunization of children, monitoring of registered pregnant women (at least four visits during pregnancy), and periodic follow up visits of registered infants[47]. If they fail to meet the performance target, "up to 20 percent of the providers' payments are withheld" (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013, p. v).

As a positive outcome of the performance system, Turkey improved maternal and child care with better immunization and regular follow-ups[48] (*Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements* 2013, p. viii). Bilge thinks that if the penalties and salary deduction threat did not exist, these vaccination and follow-up rates wouldn't be as high as today:

> I'm content with the performance system in the sense that some fellow physicians and nurses need to be subjected to a performance [system] in order to do their job properly. The departments subject to performance [system] are mostly pregnancy follow-up, vaccination of the infants and follow-up of the patients over 65 rather than patient examinations. The performance cuts are high. If you miss a pregnancy follow-up, it's around 250 liras, if you miss any vaccination, it's around 500 liras cut. Therefore everyone does their best but if it's left to the individual there won't be such follow-ups in my opinion, as I know the previous system. [48]

FHWs provide preventive services and FPs provide treatment service." Having a chance for observation in waiting rooms and my preliminary research findings allowed me to keep some distance with the family physicians' narrative and keep in mind the possibility of 'speaking for themselves'. Within the scope of this research I had to exclude the work of the family medicine personnel but one needs to keep in mind that their perspective may shine a different light on the study of the matter.

[47] Legislation On Contract and Payment Principles and Procedures to be Made to the Personnel Who Were Employed by The Ministry of Health Within the Scope of the Family Medicine Implementation (Official Journal no. 27801 of 30.12.2010)

[48] Statistically speaking, according to Performance Program for 2016 (*2016 Yılı Performans Programı*) document (2015), Vaccination rate is increased from 77% (200) to 96% (2016), infant mortality rate is decreased to 7.6 (2014) from 31.5 (2002) for per 1.000 births and mother mortality rate have decreased to 15.2 (2914) from 64 (2002).

In the Health Centers, if patients came the healthcare service was given. It was mostly the responsibility of the citizens. General practitioners were not running after the citizens for follow-ups and vaccinations. In this system, family physicians have to follow up pregnant women, infants, and children in their list. Serap is a family physician with more than 30 years of experience. She has approximately 3,900 people in her list and her FHC is located in a middle-class neighborhood. For her, if parents do not bring their children for vaccination to FHCs, they must be the responsible for not vaccinating their children as well. But in this current system, family physicians and family medicine personnel are the ones who are responsible for it. Ersin, as introduced in the third chapter, is a family physician with more than 25 years of experience, and he has a similar complaint about the one-sided responsibility for the follow-ups and vaccinations:

> With the populist policies, they put those responsibilities, which should be assumed by the individuals themselves on your shoulders. How do they do it? Let's say you have a newborn. It shows up on our screen. The infant is to be vaccinated, we have to follow and you have no responsibility, we have all the responsibility. [49]

Family physicians are faced with the problems arising from performance system application mostly in the upper-middle and upper-class neighborhoods where the population prefers to get service from private hospitals or clinics. People can refuse the healthcare service from the FHCs and family physicians are stuck in a difficult situation and facing the risk of salary deduction. Hakan as a family physician with a heavy workload in a slum thinks that the image of family physicians for the citizen turns into an insistent and *tacizkar* (disturbing) doctor and in return, family physicians like Murat can get reactions like "why do you call me? I don't want to make use of your FHCs."

During the interview, I asked Murat, who works in a upper-middle class neighborhood, whether he has problems with the performance system because of the service preferences from the private hospitals or clinics rather than FHCs, he gives this example about the situations he experienced with his population:

> This is how we experience it; we have to contact them by phone when they don't come to us. When they don't need us, they don't want to answer our phone calls. So, for instance we make a phone call, they say I don't want to use your family Health Center, why are you calling me? We tell them this is not about you, the Ministry wants us to. We have to follow up that's why we are calling. He responds it with this: "*I'm not using your services brother, why do I care?"* because s/he doesn't feel any obligation. [50]

For Murat, to prevent this kind of unfortunate encounters there is a need for a punishment mechanism such as suspending health insurance temporarily. Otherwise, family physicians can run after the citizens like a detective:

> It is expected that the physician calls the patient like a detective [by the state]. You have to pursue [the patient], go to the [patient's] house if need be. You go to the house, the guys shuts the door on your face, asks what are you doing here? [51]

They have to reach the pregnant women or the parents who refused the get service so they are not punished with a salary deduction. They need a signed document by the citizens which informs the authorities about the refusal. If they failed to document it, they can be punished. A similar encounter with patients is experienced by Aslı. As explained above, Aslı's registered population belongs to upper-middle class including famous people. Even she has a few pregnant, children and infants, she faces problems when she tries to reach them for follow-ups or vaccinations. She said that when she tries to reach them, they want to get away from you one way or another or they cannot even find them:

> We can't reach some of our patients because they have seriously high socio-economic status or they are celebrities, it's not possible to reach them. You can't find their phone number, even if you do their assistants don't let you reach them. [There are] these kind of problems. [52]

I asked her what she would do if these follow-ups and vaccinations were not performance targets and she answers:

> We would serve those that apply to us, not call the others. Would the follow up work be done properly? I don't think so. Because I know the field. But if there was positive and not negative performance it would still work properly. Now it proceeds by consuming people, it could have proceeded much nicer the other way. [53]

She thinks like Bilge thinks. Additionally, she thinks that if the performance system was presented as a rewarding mechanism, it would have been better for family physicians' satisfaction.

The discussion on deprofessionalization of family physicians is connected with the performance system. The surveillance mechanism of the performance system with punitive behavior forces family physicians to act like a detective, like Murat says, and turns their image into annoying people in the eyes of some citizens.

Thus far, I have explained the dissatisfactory encounters of the family physicians and patients because of refusal of unlawful requests. Secondly, I discussed the consequences of the punitive performance system application and its impact on the doctor-patient relationship in FHCs. The last part will discuss citizens' use of 184 SABİM by looking at different factors that trigger patient complaints about family physicians. I also look at what happens after the complaints.

4.3.3. SABIM and Complaints of Citizens

SABIM is a Ministry of Health Communication Center (*Sağlık Bakanlığı İletişim Merkezi*) which works as a call center of the Ministry of Health. It provides services for citizens' complaints, suggestions, demands, and questions about health. The SABIM project was started to be used efficiently right after the establishment of the HTP. This part aims to explain the experiences of family physicians with SABIM, citizens' using behaviors of SABIM, and their impact on doctor-patient relationship in FMI.

The standard procedure is that SABIM operators record the applications and then, SABIM analysts assess the application and they refer the application to the authorities.[49] SABIM is the meeting point for directors of the healthcare system, citizens who get service, and the healthcare providers.[50] The authorities who deal with the complaints on family physicians are the CHCs. Elif worked in CHC as a director before she worked at a FHC. Therefore, she knows how SABIM works and operates in CHCs. When I asked her opinion, she made an emphasis on the necessity of this kind of mechanism in the healthcare services. For her, it is important to see the practice in the field with complaint line. However, she added that it needs more attention and a control mechanism to detect the unnecessary and unjustified complaints because most of the complaints are unnecessary:

> I mean, it was ninety percent unnecessary. There are those who are right, sure it should exist. There need to be a line for complaints to see the field. But not everyone is good, not everyone means well. [54]
>
> There should be a sanction against this, against the false complaints and accusations. Because it breaks your motivations, having to deal with these complaints. Yes, it should be present but patients need to know their place as well as they know their rights. [55]

[49] http://www.saglik.gov.tr/TR,11429/temel-amac-ve-hedefimiz.html
[50] http://www.FHC.gov.tr/subehaberler/SABIM_5579.dnz

How SABIM operates is similar to the performance system. It also ignores the family physicians' satisfaction and their rights. While citizens do not have any responsibility for their follow-ups and vaccinations for children, there is no penalty to citizens for false statements to SABIM. Aslı thinks that it is also related to lack of knowledge and government policies: "I think now, people apply to 184 without knowing how the system works and depending on the message from above [the government], the message of "they [family physicians] have to do whatever you want" [56].

A SABIM crisis occurred once in Ayben's FHC. Ayben was called by CHC upon a complaint via ALO184. She was accused of keeping a patient waiting in the morning. The patient says he went to the FHCs at 9 o'clock and knocked on the door of his family physician. Family physicians told him to wait for couple of minutes. The patient waited for two minutes and then called ALO184. His accusation includes exaggerated feedback about the situation, threats, and insulting words. Ayben as a complainee checked the working hours when the event occurred and recognized that she accepted 20 patients during the time he specified. Later, it is understood that complainer called ALO184 and gave the wrong family physician's name as Ayben. His family physician who told him to wait was dealing with paying the salary of the personnel in the FHCs since she had to pay the personnel's salary during the time he wanted to come into her room for examination. He lied about his family physicians' situation and said that she was smoking and talking with her friends for an hour. The case includes false accusation about her family physician's behavior, wrong information about the family physician's identity, threats and insulting words, and lastly, impatience.

While she was telling this story to me, she looked so exhausted and said: "This is a section of society who thinks that they are entitled to anything without knowing the rights" [57]. Arda was also reported by a citizen who wanted a report. The requested report should be

given by the sports medicine doctor and therefore, Arda refused to give this report to him and referred him to the authorized doctor. As a result, he called SABIM. Most of the family physicians are overwhelmed with this line. It creates uncertainty and a fear of false declaration by the patients even when they stick to the law. Depending on the complaints to SABIM, FHCs can be audited with an extraordinary inspection by supervisors from CHCs. The complaints can also be used for *mobbing* for family physicians by the supervisors of CHCs. For instance, although the complaints should have been neglected because of not being a serious complaint, in Mert's case, the complaint was not neglected. He was also complained about via ALO184. When there is a queue before the lunch break, he and his co-workers locked the door at 11.30. If they do not close the door, they cannot have a chance for a lunch break. One patient came to FHC at 11.55 and the door was closed. He reported this to ALO184 and then supervisors came for inspection as soon as possible:

> [Sarcastically] Community Health Center loves it, of course they showed up since we are not in good terms. They came with the speed of light. What they do is to check whether I examined a patient at that hour. I accepted patients until quarter past 12 that day so they said fine and left. [58]

In Ayben's case, she was called by CHC and informed about the compliant. However, in Mert's case, he was not called but rather, he was exposed to an extraordinary inspection and what he did was not against the rules and regulations. Before they left, Mert stopped them and asked:

> You come and check whether patients were examined or not at this time. What you should be doing instead is to investigate why we have patients until quarter past 12, why is there such density, why is this the case? It can be because of us or because of the district itself. What is your aim? [59]

Their answer to this question was that their purpose is to check whether the patients are examined or not. For Mert, it does not solve problems. Rather, they do it for mobbing/disturbing.

Most family physicians I interviewed are not against to the SABIM. They are against the way it is used. Organizational measures for improving patients' rights and satisfaction by the government causes a number of problems in doctor-patient relationships in the FHCs. When patients complain about their experience to SABIM, the nature of the relationship changes and reshapes with the attendance of the third authority as it can be seen from the examples I gave. As a result, although family physicians declared that they are not against the patients' rights; but they are against the implementations like SABIM which are used as a threat or a mobbing mechanism against the family physicians.

4.4. Conclusion

In the third chapter, I constructed my analysis on the deprofessionalization of family physicians by also focusing on the neoliberal governmentality. I also displayed the effect of the neoliberal and populist policies' complex relationship in the FHCs to the medical practice of the family physicians and the doctor-patient relationship in the FHCs.

The problems mentioned above do not always arise from the consumerization of patients in the market-driven reform or the populist policies of the governments. Family physicians' level of satisfaction with their medical expertise and the relationship between doctor-patient relationships can also be shaped by family physicians' personality, age, and gender. These factors are not considered as a determinant. The risk for this chapter is to construct the whole argumentation on the family physicians' perspective. While doing this, I did not include the voice of other medical staff in FHCs, patients, and the authorities. Although this chapter contains the possibility of a mismatch with the implementation in the FHCs, I should remind

that the outcome of the chapter consists of the family physicians' interpretations, fears, anxieties, satisfactions, and reactions, *either positive or negative*.

CHAPTER 5

5. Conclusion: Family Medicine as a *Ragbag*

Throughout this thesis, I sought to demonstrate the structure of Family Medicine Implementation (FMI) which reshapes the daily routine of the family physicians in the primary healthcare services, based on interviews with family physicians. Turkey adapted to the neoliberal transformation which begun with Britain in late '70s only after the establishment of the Health Transformation Program (HTP) in healthcare services. There were minor changes with the help of the World Bank (WB) and International Monetary Fund (IMF) in the healthcare sector, which were the earlier signals of the neoliberal attempts. Yet, the major reform in healthcare services was achieved in Justice and Development Party (JDP) era of Turkey. There is an ongoing process with the adaptation to these components of the reform. Citizens and healthcare providers are getting familiar with these neoliberal changes in the healthcare sector. On the other hand, there are internal dynamics which also shape the experience of the acquaintance with the new algorithm of the healthcare services. As I explained in the fourth chapter, the internal dynamics are basically constituted by the populist policies of the government. Herein, I wanted to display how the neoliberal and populist policies melt into each other and formed the primary healthcare services' daily routine and how the experience of the family physicians in the Family Health Centers (FHC) differ from one to another which do not correspond to the government's neoliberal agenda as expected.

The implementation of Family Medicine is constructed on a shaky ground, creating confusion and ambiguity in family physicians' mind and manifesting as feelings of dissatisfaction and insecurity. This is not the case for each family physician I interviewed. However, in Aslı's case, she uses the word "ragbag" to symbolize the implementations' reflection on the family physician's mind. Ragbag can be used for "an unorganized collection

or mixture of various things."[51] There is a technique in quilting called as crazy patchwork (also known as "quilt as you go") which allows you to combine different pieces of material together without a proper plan and allows you to decide what you want to do with it on the fly. In the third chapter, I used Arda's "kervan yolda düzülür" (One makes up as s/he goes along) statement to explain how the things are practiced over the years of FMI. The implementation has similar patterns with this specific art technique, *crazy patchwork*. However, in this case, policy-making for health cannot be formed with this kind of technique in which the process shapes the total work. I think Aslı and Arda have specific points in their exemplifications. They refer to the unpreparedness and unplanned structure of the FMI, which causes constant reorganization of the field. Therefore, it results in job dissatisfaction and problematic relationships with patients for family physicians.

Before going into the family physicians' experiences as managers and professionals in the FHC, I introduced the FMI with its historical background and specific components, which are significantly related with the concerns of the thesis. This chapter was organized as a descriptive one to prepare the reader for the next two chapters.

The third chapter began with a general debate about the hybrid form of the management and the profession, which leads quasi-market practices in the healthcare services. Then, the focus turned towards the family physicians' status. I illustrated how the status can be defined from very different angles according to the needs, expectations, and perspectives of the family physicians but not according to the laws, which clearly define the status of family physicians. The ambiguity also affects the mobilization patterns and unionization variety of the family physicians. On the one hand, the Turkish Medical Association (TMA) is struggling with the health reforms' effects on the doctors and positions itself as being against the aim of the

[51] https://www.merriam-webster.com/thesaurus/ragbag

reforms, such as privatization of healthcare services and the emphasis of the clients rather than patients. On the other hand, an employer union was established which approves the privatization tendency of the government with its very existence even if the union works for the rights of the family physicians. The third chapter continues with the daily routine of management in the FHCs which projected the managerial part of the family physicians. In this part, I aimed to show the different experiences of the family physicians as managers.

Family physicians receive a generous salary which consists of current expenditure payment and monthly salary as it is explained in the second chapter. The first one is determined by the specific criteria especially based on the location of FHC and its category. Family physicians as managers have the responsibility for how to spend this money. They can either spend the whole current expenditure for the expenses of FHC like Bilge or keep most of the current expenditure for themselves like Hakan. Another scenario is the scenario where the current expenditure is not enough to run the FHC, which is displayed in Coşkun and his coworkers' case. The problems may arise from the lack of knowledge/training on managerial skills, different preferences for spending the given budget in the same FHCs, and high and unaffordable rents for Sanal FHCs. It depends on many factors such the personal characteristics of the family physicians and the coworkers whom they work with and the location of the FHCs. In this chapter, I brought the consequences of the ambiguity of status and their manager positions to the forefront with an emphasis on the complexity of the implementation in the field, which sometimes prevents spending time on practicing medical expertise.

Following this, the fourth chapter addressed how the family physicians experience their doctoring practices (controlled under the performance system) and what they think about the doctor-patient relationships (transformed to a provider-client form after the HTP). In order to explain these two significant issues, I firstly introduced *deprofessionalization* focusing on the

loss of autonomy of the doctors. On the one hand, the State pressures family physicians with the performance system, which aims to control and regulate them, and on the other hand, there are patients who are provoked against doctors, mostly because of the populist policies. The emphasis on the satisfaction of the citizens as a consequence of market-based practices and populist policies resulted in single-sided satisfaction that ignores the healthcare providers' distress.

Even so, because of the person-list based healthcare services most of the family physicians I interviewed are satisfied with the increased familiarity with their patients. They started to get to know their registered population better and they are now able to regularly follow up their health conditions. But in contrast to this positive outcome of the FMI, I demonstrated the situation, especially in the lower/middle class neighborhoods, as an example; Family physicians cannot allocate enough time for preventive healthcare services. Because of the performance system, they have to achieve the monthly performance targets. However, if for instance the family physician works in a FHC with a heavy workload, like Ayben and Elif, the duration for preventive healthcare is limited to minutes and they cannot spare additional time for things like the education of pregnant women. In addition, I illustrated that the practice is also used as a tool for populist purposes in the eyes of the family physicians. It was suddenly added to the implementation from above and family physicians were forced to take shifts and it seemed like a pragmatic concern of the government which is not a population need but rather a tool to pursue the image of accessible healthcare anytime, anywhere in the citizens' mind. In return, a considerable amount of family physicians are affected and distressed by the health policies in the FHCs.

So far, I showed the examples of how family physicians' perspectives are shaped by the policies and how they express themselves while talking about their job. In the third part of the

chapter, I looked at the expectation and satisfaction patterns of the patients through the eyes of family physicians. What family physicians see when they encounter patients were the initial concern for this part.

The next section of the chapter dealt with the emphasis of the patients' rights and their satisfaction and how it is reflected to family physicians. As displayed, the inverse correlation between the family physicians' and patients' rights created unequal relationship between two. The unlawful demands and unjustified requests from family physicians become more common in the FHCs when it is compared with the past. Although there are laws, low health literacy rate and 'provoking' patients against doctors via populist policies are reflected in these kinds of encounters, as in Can's case, which may result in threat, cursing or other kinds or types of violent conduct. In order to link the discussion with the loss of prestige we must consider the performance sysyem; for family physicians, the reason for transformation of family physicians into disturbing characters is the performance system. The system forces family physicians to reach any patient on the performance target list. However, patients do not have such responsibility for coming to their regular follow-ups, during pregnancy or when vaccinating their children in the FHCs. Since they prefer to go to private hospitals and clinics and undermine the public healthcare services, they refuse to get service from FHCs, especially in the upper-class neighborhoods. Therefore, many problems occurred between the family physicians and their populations like what happened to Murat and Aslı. This part showed that the cost of this conflict might result in arguments with patients and salary cut. Lastly, I exemplified how SABIM can create such a threat mechanism towards family physicians and how it can be used for mobbing by the supervisors.

This thesis provided an analysis of family physicians' perspectives on FMI and their experiences in FHCs after the implementation of Family Medicine. I choose family physicians

as the core subject in this research since my concern is beyond the relationality between these actors. I was also wondering how family physicians work in the new implementation of primary healthcare services as being both managers and professionals. Further research is necessary for making more comprehensive analysis to unfold the complexity of the relations between the State, family physicians, family health personnel, and the patients. Therefore, inclusion of the other actors and making them speak is suggested for the next research.

BIBLIOGRAPHY

Ağartan, T. I. (2012). Marketization and Universalism: Crafting The Right Balance in The Turkish Healthcare System. *Current Sociology, 60*(4), 456-471. doi:10.1177/0011392112438331

Ağartan, T. I. (2015a). Explaining Large-Scale Policy Change in the Turkish Health Care System: Ideas, Institutions, and Political Actors. *Journal of Health Politics, Policy and Law, 40*(5), 971-999. doi:10.1215/03616878-3161174

Ağartan, T. I. (2015b). Health Workforce Policy and Turkey's Health Care Reform. *Health Policy, 119*(12), 1621-1626. doi:10.1016/j.healthpol.2015.09.008

Akdağ, R. (2009). *Health Transformation Program in Turkey* (749). Retrieved from Ankara.

Akdağ, R. (2012). *Health Transformation Program Assesment Report (2003-2011)*. Retrieved from Ankara.

Altınc Beş Yıllık Kalkınma Planı 1990-1994 (Sixth Five-Year Development Plan 1990-1994). (1989). Ankara: State Planning Organization.

Bonsignore, C., Brolis, E., Ionescu, A., Karusinova, V., Mitkova, Z., Raps, F., . . . Fedotova, N. R. Patient Empowerment and Centredness.

Bourdieu, P. (1984). *A Social Critique of the Judgement of Taste* (R. Nice, Trans.). Cambridge, Massachusetts: Harvard University Press.

Brady, M. (2014). Ethnographies of Neoliberal Governmentalities: from the neoliberal apparatus to neoliberalism and governmental assemblages. *Foucault Studies*(18), 11-33.

Causer, G., & Exworthy, M. (1999). Professionals as Managers across the Public Sector. In M. Exworthy & S. Halford (Eds.), *Professionals and the New Managerialism in the Public Sector* (pp. 83-101). Buckingham, Philadelphia: Open University Press.

Cevahir, E. (2016). *Türkiyede Sağlık Sisteminin Dönüşümü: Toplumsal Yansıma Örnekleri*. Kadıköy, İstanbul: Kibele

Correia, T. (2016). Doctors' Reflexivity in Hospital Organisations: The Nexus Between Institutional and Behavioural Dynamics in The Sociology of Professions. *Current Sociology*, 20. doi:10.1177/0011392116641478

Dorlach, T. (2016). The JDP Between Populism and Neoliberalism: Lessons from Pharmaceutical Policy. *New Perspectives on Turkey, 55*, 55-83. doi:10.1017/npt.2016.23

Erkoç, Y. (2012). *Turkey Health Transformation Program Assessment Report (2003-2011)*.

Exworthy, M., & Halford, S. (1999). Professionals and Managers in a Changing Public Sector: Conflict, Compromise anc Collaboration? In M. Exworthy & S. Halford (Eds.), *Professionalism and the New Managerialism in the Public Sector* (pp. 1-18). Buckingham, Philedephia: Open University Press.

Foucault, M. (1997). *Discipline and Punish: The Birth of the Prison* (A. Sheridan, Trans.). New York: Pantheon.

Gabe, J., Bury, M., & Elston, M. A. (2009). *Key Concepts in Medical Sociology*. Great Britain: SAGE Publications Ltd.

Gordon, C. (1991). Govemmental Rationality: an ntroduction. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect Studies in Governmentality.* Chicago: University of Chicago Press.

Gouldner, A. (1979). *The Future of Intellectuals and the Rise of the New Class: a Frame of Reference, Theses, Conjectures, Arguments, and an Historical Perspective on the Role of Intellectuals and Intelligentsia in the International Class Contest of the Modern Era*. New York: Seabury Press.

Gökler, M. E., Egemen Ünal, Reşat Aydın, Gülsüm Öztürk Emiral, Selma Metintaş, Burhanettin Işıklı, & Önsüz, M. F. (2016). Toplum Sağlığı Merkezi Sorumlu Hekimlerinin Gözüyle Toplum Sağlığı Merkezlerinin Genel Özellikleri *Turkish Journal of Public Health, 14*(2), 56-67.

Gülbiye Yenimahalleli Yaşar, A. G., Ömür Birler. (2015). *Türkiye'de Sağlık Siyaset Piyasa*. Ankara: NotaBene.

Günal, A. (2008). *Health and Citizenship in Republican Turkey: An Analysis of The Socialization of Health Services in Republican Historical Context.* (PhD Dissertation), Boğaziçi University, Istanbul.

Güzelsarı, S. (2012). The Restructuring of Health Care System and Public-Private Partnerships. *TODAIE's Review of Public Administration, 6*(3), 33-64.

Halford, S., & Leonard, P. (1999). New Indentities? Professionalism, Managerialism and the Construction of Self. In M. Exworthy & S. Halford (Eds.), *Professionals and the New Managerialism in the Public Sector* (pp. 102-120). Buckingham, Philedelphia: Open University Press.

Haug, M. R. (1975). The Deprofessionalization of Everyone? *Sociological Focus, 8*(3), 197-213. *Health Promotion Glossary*. (1998).

Heritage, J., & Maynard, D. W. (2006). *Communication in Medical Care: Interaction between Primary Care Physicians and Patients*. Cambridge, UK: Cambridge University Press.

Hudson, B. (1992). Quasi-Markets in Health and Social Care in Britain: can the public sector respond? *Policy and Politics, 20*(2), 131-142. doi:https://doi.org/10.1332/030557392783054874

Keyder, Ç., Üstündağ, N., Ağartan, T., & Yoltar, Ç. (2007). *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar* İstanbul: İletişim Yayınları.

Köse, M. R. (2016). *Sağlık İstatistikleri Yıllığı 2015 (Health Statistics Annual 2015)*. (1054). Ankara: Ministry of Health.

Köse, M. R., Başara, B. B., Güler, C., Soytutan, İ., Aygün, A., Özdemir, T. A., . . . Kılıç, D. A. (2016). *Sağlık İstatistikleri Yıllığı 2015 (Health Statistics Annual 2015)*.

MacFarlane, K. A., O'Neil, M. L., Tekdemir, D., Cetin, E., Bilgen, B., & Foster, A. M. (2016). Politics, Policies, Pronatalism, and Practice: Availability and Accessibility of Abortion and Reproductive Health Services in Turkey. Reprod Health Matters, 24(48), 62-70. doi:10.1016/j.rhm.2016.11.002

McDonald, R. (2014). 'Bourdieu', Medical Elites and 'Social Class': A Qualitative Study of 'Desert Island' Doctors. *Sociology of Health & Illness, 36*(6), 902-916. doi:10.1111/1467-9566.12121

McKinlay, J. B., & Marceau, L. D. (2002). The End of the Golden Age of Doctoring. *International Journal of Health Services, 32*(2), 379-416. doi:10.2190/JL1D-21BG-PK2N-J0KD

Mehtap Tatar, Salih Mollahaliloğlu, Bayram Şahin, Sabahattin Aydın, Anna Maresso, & Hernandez-Quevedo, C. (2011). *Turkey: Health system review*.

Metsemakers, J. F. M. (2012). Family Medicine Training in Turkey: Some Thoughts. *Turkiye Aile Hekimligi Dergisi, 16*(1), 23-34. doi:10.2399/tahd.12.023

Olssen, M., Codd, J. A., & O'Neill, A.-M. (2004). *Education policy: Globalization, citizenship and democracy*: Sage.

Ozsahin, A. K. (2014). Family Practice in Turkey. *IUHPE – Global Health Promotion, 21*(1), 59-62. doi:10.1177/1757975913503666

Öcek, Z. A., Çiçeklioğlu, M., Yücel, U., & Özdemir, R. (2014). Family Medicine Model in Turkey: A Qualitative Assessment from The Perspectives of Primary Care Workers. *BMC Family Practice, 15*(1), 38. doi:10.1186/1471-2296-15-38

Önder, S. W. (2007). *We Have No Microbes Here: Healing Practices in a Turkish Black Sea Village*. Durham, North Carolina Carolina Academic Press.

Parsons, T. (1939). The Professions and Social Structure *Social Forces, 17*(4), 457-467.

Reich, A. (2012). Disciplined doctors: the electronic medical record and physicians' changing relationship to medical knowledge. *Social Science & Medicine, 74*(7), 1021-1028. doi:10.1016/j.socscimed.2011.12.032

Smith, D. E., & Griffith, A. I. (2014). *Under New Public Management : Institutional Ethnographies of Changing Front-line Work*. Toronto: University of Toronto Press, Scholarly Publishing Division.

Sönmez, M. (2012). *Paran Kadar Sağlık: Türkiye'de Sağlığın Ticarileşmesi*. İstanbul: Yordam Kitap.

Şeker, M. (2015). Quality of Life Index: A Case Study of Istanbul. *Ekonometri ve İstatistik Dergisi (Journal of Economy and Statistics), 23*, 1-15.

Tanrıöver, M. D., Yıldırım, H. H., Ready, F. N. D., Çakır, B., & Akalın, H. E. (2014). *Türkiye Sağlık Okuryazarlığı Araştırması (Turkey's Health Literacy Research)*.

TMA. (2011). *Sağlıkta Hayaller, Yalanlar ve Gercekler (Illusions, Lies and Truth in Healthcare)*.

TUİK. (2017). Genel Olarak Kamu Hizmetlerinden Memnuniyet, 2013-2016 (Satisfaction from Public Services in Generali 2003-2016). Ankara: Turkish Statistical Institute.

Turkey Performance-Based Contracting Scheme in Family Medicine - Design and Achievements (77029-TR). (2013). Washington, USA.

Türem, Z. U. (2016). Engineering Competition and Competitive Subjectivities: "Self" and Political Economy in Neoliberal Turkey. In A. Terzioğlu, C. Özbay, M. Erol, & Z. U. Türem (Eds.), *The Making of Neoliberal Turkey* (pp. 33-52): Ashgate.

Türk Tabipler Birliği Çalışma Raporu 2016-2017(Turkish Medical Association Working Report 2016-2017). (2017).

Ulutaş, Ç. Ü. (2011). *Türkiyede Sağlık Emek Sürecinin Dönüşümü (The Transformation of Health Labor Process in Turkey)*. Ankara: Notabene.

Wacquant, L. (1991). Making Class: The Middle Class(es) in Social Theory and Social Structure. In S. G. McNall, R. F. Levine, & R. Fantasia (Eds.), *Bringing Class back in: Contemporary and Historical Perspectives* (pp. 39-64). Boulder: Westview Press.

Ward, S. C. (2011). Commentary: The Machinations of Managerialism: New Public Management and The Diminishing Power of Professionals. *Journal of Cultural Economy, 4*(2), 205-215. doi:10.1080/17530350.2011.563072

Warwicker, T. (1998). Managerialism and the British GP: the GP as manager and as managed. *The International Journal of Public Sector Management, 11*(2/3), 201-218.

Yılmaz, V. (2014). *Health Reform and New Politics of Health Care in Turkey.* (PhD Dissertation), The University of Leeds.

Yoltar, Ç. (2009). When the Poor Need Health Care: Ethnography of State and Citizenship in Turkey. *Middle Eastern Studies, 45*(5), 769-782. doi:10.1080/00263200903135562

APPENDIX: ORIGINAL QUOTES

[1] Şimdi İstanbul'da özellikle sisteme bu kadar çabuk geçileceğini kimse tahmin etmiyordu. 2010'da 2011'de geçilecek deniyordu ama bu biraz daha uzar diyorduk. Çünkü İstanbul büyük bir şehir. Çok ani bir geçiş oldu ve herkes yaparak öğrendi. O iki haftalık eğitimle mümkün değil öğrenmek. İlk başta tabii kargaşalar oldu ama herkes yaparak öğrendi. […] O açıdan paldır küldür bir geçiş oldu ama oldu. Pek çok şeyde olduğu gibi, oldu yani.

[2] Düzce'de bu sistem süper gider ama İstanbul'da değil. Çok büyük bir alan, bir kent olduğu için burası, burada bu sistemin yürümesi zor. İstanbul için, bir ayrıcalık yapmaları lazım.

[3] E şimdi şöyle yapıyorsun, biz sağlığı yapılandırırken, bütün Türkiye için aynı şekilde yapılandırıyoruz. Esasında bu çok yanlış. Mesela İstanbul için sağlık farklı yapılandırılmalı. Perifer için farklı yapılandırılmalı.

[4] Biz ne olduğumuzu bilmiyoruz işin doğrusu. Kamu muyuz; özel miyiz? Çünkü devlet istediği zaman bizi kamu olarak görüyor, istediği zaman özel olarak görüyor. […] Hani bir laf vardır: ne at ne eşek; katırız biz aslında. Yani at da değiliz, eşek de değiliz. Ne olduğumuz belli değil.

[5] Mesela sizi özel bir işletme gibi tanımlıyor, yeri gelince size özel diyor, işine gelince devletsin sen diyor bunları yapmıyor. Yani idareciler, hangi yönde isterlerse sizi o şekilde görüyorlar. Çünkü sizin özel yasanız yok. Soruşturma ve disiplin yönünden 657; işletme olarak özel.

[6] Ben hiçbir zaman patronum demedim dedim ama bu sistemde ben patronum dedim ve bunu idaredeki aklı basında insanlar kabul ettiler zaten, öylesin de dediler ama hemşire arkadaşlar şikâyet etti.

[7] Sonuçta hepimiz kapitalist düzenin neferiyiz, bu yaştan itibaren de değiştiremeyeceğimizin farkındayız. Ben de sağlık ücretsiz olsun diyorum ama olmuyor öyle bir şey. Kapitalist sistemin mağduruyuz da savunucusuyuz da aynı zamanda. Benim iyi bil hayta yaşamam lazım, çoluğuma çocuğuma bir şeyler bırakmam lazım.

[8] Yanlış değerlendirmeyin beni ama ben kapitalist sistemin neferiyim. Benim işim para kazanmak. Ben tipik bir örneğim yani. […] Ben hekimlik yapıcam, mesleğim bu sonuçta. İyi bir şekilde yaşamak istiyorum sonuçta. İyi yemekler yiyeyim, iyi yerlere gideyim, iyi tozayım, derdim bu benim.

[9] Hani öyle kesin hatları yok. Şuyuma saygı gösteriyor, buyuma saygı göstermiyor diyemem ama hani herkesin ağzında şey var, eskiden de vardı: 'ama benim verdiğim vergilerle senin maaşın ödeniyor'. O artık biraz şeye döndü, 'sizi boşuna öldürmüyorlar'a döndü.

[10] Şöyle yani tabi, o konuda biraz geç kaldı. Aile hekimliği modeline geçildikten çok uzun süre sonra TTB bu konuda aktif hareket etmeye başladı. […] Aile hekimliği sistemi tamamen serbest piyasa ekonomisine dayandığı için, TTB'nin karşı olduğu bir sistemdi.[…] biz TTB olarak ne diyoruz: hekimle hasta arasına asla para girmeyecek; çünkü sağlık hizmetlerine ücretsiz sağlığa erişebilmeli herkes. Bundan dolayı bir karşı çıkış oldu yıllar önce. Bu karşı çıkış tabi, eee, biraz şey oldu yanlış yönlere gitti yani bu sefer aile hekimliği sistemine geçmek zorunda olan arkadaşların da hakları, özlük hakları savunulamaz oldu. Çünkü TTB bunla ilgili hiçbir şey yapmadı, sonra biz girdik işin içine.

[11] Ben memuriyeti de kabul etmiyorum, Memur diye bir şey yok. Memur, devlete çalışan işçiye deniyorsa, evet yani biz memuruz. Biz statü olarak, mademki emeğimizi satarak para kazanıyoruz, hekimliğimizi, hemşireliğimizi satarak para kazanıyoruz, biz işçiyiz. Dolayısıyla, sendikalarımız da işçi sendikası olmak zorunda.

[12] Burası nöbet tutulmaya müsait bir yer değil. Biz burada acil servis veremeyiz. Öyle bir teşkilatlanmamız, yapılanmamız yok. Öyle bir personelimiz, envanterimiz yok ama bize diyorlarsa ki, acil olmayan hastalara cumartesi bakılsın.

[13] Ben parayı tahsil edemedim. Edemem. Niye? Çünkü onun oradan çekip gitmesinde, orası bir işletme; ama siz herhangi bir bakkal dükkânında 2-3 ortalıklı bir bakkal dükkânında, ortağım ben buradan çekip gidiyorum dediği zaman ne yaparsınız, otursunuz bir mutabakat yaparsınız, öyle değil mi? Ne yazık ki, AH'de internet, telefon bir kişinin üzerine. Su faturası bir kişinin, kira kontratı da bazen bir kişinin üzerine. Benim ortağım giriyor kuraya, çekip gidiyor ve ben bu idare nezdinde hiçbir şey yapamıyorum ki parasını alamıyorum, hukuken de bir şey yapamazsın.

[14] Siz aile hekimlerine 'git, aile sağlığı merkezi aç', diyemezsiniz. Bunu, Bayburt'ta dersiniz, verdikleri cari giderle, gider, kiralarla şey yaparlar; ama şu anki mevcut uygulama yönetmeliğindeki metrekareleri tutturacak 5 kişilik bir aile sağlığı Merkezi'ni, eğer X'te açmak isterseniz, açamazsınız.

[15] Ben tek başıma ayrı bir yer buldum. Yaklaşık 1 ay sokak sokak dolaştım, bir ayakkabı eskittim.

[16] Diğer iki arkadaş, tuttukları yerin kirası çok yüksek olduğu için, işletme maliyetleri, aldığı maaşlar işletme maliyetlerini karşılayamadığı için battılar. Aynen böyle. Battılar. Yaklaşık 125 milyar yatırım yaptılar, bodrum ahır gibi bir yeri çok iyi standartlarda bir Asile Sağlığı Merkezi haline getirdiler ve bunu ceplerinden parayla yaptılar. Daha sonra bizim asli mesleğimiz hekimlik olduğu için, biz ticaret adamı olmadığımız için bu konulara hâkim olmadığımız için ve bu arkadaşlar da hâkim olmadıklarından dolayı işletme olarak battılar, Aile Sağlığı Merkezi'ni ekstra 100 milyar zararla terk etmek zorunda kaldılar.

[17] İnsanları 20-25 yıl bin lirayla çalıştırıp, sonra cebine beş bin lira koyarsan, ilk etapta doktorlar da memnun olur, sağlık çalışanları da memnun olur. Ama ondan sonra artışlar değil; çıkışlar başladı sistemden.

[18] Şöyle karşılaştırayım, sağlık ocağındayken de acildeyken de daha fazla çalışıyordum, yarım maaş alıyordum hatta daha az alıyordum. Şeydeyken, toplum sağlığında yöneticiyken, kafa olarak, sorumluluk olarak daha fazla işim vardı, yine yarım maaş alıyordum. Burada, yani yapılan iş sağlık ocağı sisteminde göre yarıya indi, alınan maaş 2 katına çıktı. Gerçi burası yoğun da, diğer yerlere göre, ortalama açısından söylüyorum.

[19] İstifa ettim, bir müddet hasta bakmayacağım. Meslekten soğuduğum için, insanlara da tahammül edemiyorum artık. Hasta bakarken mesela, eskisi gibi iyi dinleyemiyorum.

[20] 8, elime kalan. Harcamalar dışında sekiz elime kalıyor. 8 kalıyor da, ben verim 8 rahat olayım. İstemiyorum yani yapmak sekiz bin liraya şu işi. Çünkü her ay sıkıntın var, her ay stresin var. [...] Maaş olarak çok iyi ama yaptığımız iş iş değil. Yani yaptığımız şey doktorluk değil. Hani ne bileyim, sekiz bin lirayı öğretmene de versen, bir yıl yanında oturtsan, birinci yılın sonunda yaptığım işi öğrenir, o da yapar yani bu işi. Vaka yok, hasta yok, gördüğümüz şeyler hep aynı şeyler. Kör yani. Ama maaş iyi. Ama ben o kadar mutsuzum ki, 8 bin lirayı bırakıp, 5 bin lira maaş alacağım bir yere gidiyorum, mesleki açıdan tatminsizim.

[21] Nüfus için aldığımız para 5 bin civarında, nüfus sayısına göre değişiyor. Onun dışında cari gider de 4 bin lira kadar. Maaşın yüksek olmasını sağlayan da o. Totalde yüksekmiş gibi gözükmesini sağlayan herkes biliyor ki, 5 bin liraya şu çileyi çekmez.

[22] Şimdi şöyle bir şey, devlet biliyor ki buraya 5 bin liraya doktor koyduğunda, doktoru çalıştıramaz. Devlet, ben sana 9 bin lira para veriyorum, naparsan yap, diyor. Burası normalde 16 bin liraya da dönebilir ama biz 4 bin liraya döndürüyoruz. Ama böyle bir şey söz konusu

olabilir mi? Olamaz. Devlet de farkında bunun. O 4 bin liranın hepsinin bunun için harcanmadığının farkında

[23] Ben içime sine sine her şeyi yapıyorum ama hani aldığı cari gidere maaş gözüyle bakan ve yaptığı her cari gideri kendi cebinden kendi maşından gidiyor gibi düşünen hekim arkadaşlarımız var, o zaman ona batıyor tabi.

[24] Az önce mesela bizim denetlenmemiz vardı, denetimde hani çok temiz vb.ye bakılmıyor. Bakılması lazım aslında ama çok bakılmıyor. Nelere bakılıyor, mesela bebek tansiyon aleti var mı erişkin tansiyon aleti var mı stetoskop var mı ona bakılıyor, ısınması havalandırması var mı ona bakılıyor. Ama içerisinin dekorasyonuna çok bakmıyorlar açıkçası. Ondan yani temizlik, kullanılan malzeme, evimizde hangi temizlik malzemesini kullanırsak biz, buraya da onu alıyoruz, burada çok vakit geçirdiğimiz için. Her yerde öyle değil tabii, tuvalet kâğıdını cebinde getiren, sonra tekrar evine götüren hekim arkadaşlar da var. Tamamen kişinin inisiyatifine kalmış bir sistem bu. Denetleniyoruz ama dediğim gibi, bu denetim çok yeterli bir denetim değil.

[25] Yani bak biz şu an toplumu konuşuyor muyuz? İnsan sağlığını konuşuyor muyuz? Konuşmuyoruz. Neyi konuşuyoruz? Parayı konuşuyoruz, maliyeti konuşuyoruz, bu işten nasıl kotarırız onu konuşuyoruz. Bu işi nasıl daha ucuza kapatırız, onu konuşuyoruz. Biz topluma nasıl daha iyi hizmet verebiliriz, hizmet standardını nasıl arttırabilirizi konuşmuyoruz. Ucuza kirayı nerede bulabiliriz, bir hekim bunu konuşuyor. Bir hekimin işi bu mudur?

[26] Hastalar haklarını bilmiyor. Hasta hakları konusunda bir eğitim de kendilerine verilmiyor. Hasta haklarını ihmal etmeye de yönlendiriliyor. Yani hasta, hastayı memnun edelim. Yani şu anki politika hasta, nereye müracaat ederse etsin, memnun edilsin. İşi görülsün. Yani, böyle bir sağlık sistemi dünyanın hiçbir yerinde yok. Böyle bir hekimlik de yok ama böyle bir hasta kitlesi oluşturuldu. […] Acil servise burnu akıyor diye gidiyor, niye? Gündüz gidemiyorum

doktoruma, acile gideyim. […] Doktora gidemiyorum diye burnu akan acil servise gidiyor ve bunu kendine hak görüyor ve şu andaki politikalar da bunu destekliyor.

[27] Daha iyiydi çünkü o zamanki hastalar şu anki kadar hakları ihlali ve hakkı olduklarına karşı cesaretlendirilmemişlerdi. Bunu yapan zaten cahil kesim bunlar. Yani sizin gibi okumuş insanlar burnum akıyor diye, acil servise gitmezler. Cahil insanlar bu konuda cesaretlendiriliyor. Ya sorumlusunu ben insan olarak görmüyorum. Bu cesareti ona veren kişilerdir bu işin sorumlusu. Bu hakkı ona verendir. O kişiye acil servise gitme hakkı olmadığını, oraya gittiğinde reddedileceğine, oradaki sağlık ekibinin onu reddetme hakkı olduğunu bilmesi lazım, bunu öğrenmesi lazım. Hasta eğitimi budur. Hasta eğitimi, şekerin varsa ağzın kuruyorsa, git şeker baktır demek değildir.

[28] Toplumun her kesiminde şiddet olayları tırmanıyor, tabii sağlıkta da tırmanıyor. Hükümet, sağlıktan çok büyük oy aldı. Oyların bu kadar çok yükselmesinin çok büyük bir etkeni sağlık. O yüzden de çok büyük tavizler veriliyor. Hasta zaten bilenmiş bir şekilde geliyor doktora. Sağlıkta şiddet, çok arttı tabii.

[29] Esas amaç koruyucu hekimliktir. Biz bunlar yapamıyoruz sadece tedavi edici kısmında, hani reçete yazmakla falan uğraşmak zorunda kalabiliyoruz. Hastalar o konuda sıkıntı oluyor, dışarda bekleyenler. Sonuçta biz orda hastadır gebedir bebektir, onu takip etmemiz gerekiyor. Dışarda baya ses yükselebiliyor.

[30] Bizim ASM biraz düşük tabii; ama mesela bir gidin Esenler'e, 100-80 o civarlarda bakanlar var yani.

[31] Eğitim çok önemli. Hasta geldiğinde benim burada ona eğitim verebilmem lazım. Herhangi bir konuyla ilgili. Kadınsa meme muayenesi, işte smear almaya yönlendirmem lazım, çocuğu varsa ishal olduğunda ne yapacağını bilmesi lazım, ateşi çıktığında ne yapacağını bilmesi lazım. Bunları elimizden geldiğince yine yapıyoruz ama vakit kalmayabiliyor; çünkü

acayip bir poliklinik yükü var. Bizi en çok zorladıkları şey o, poliklinik yapın. Gelen her hastaya bakacaksınız. Sistem şu an öyle dönüyor, herkes poliklinik yapıyor sadece.

[32] Bu odaya kapanıyoruz. Hasta geliyor gidiyor, hepsini muayene ediyorsun. Fazla zaman ayıramayabiliyorsun her hastaya. Şeye benziyor, bataklığı kurutmadan sürekli sıtmayı tedavi etmeye çalışmak gibi.

[33] Şu anda odaklandığımız şey nöbet tutacak mıyız tutmayacak mıyız, orda kaldık yani. Hani bizim bölgede yapılabilir mesela; ama onu bile yapamıyoruz. Çünkü bambaşka işlerle uğraşıyoruz.

[34] Yani çalışma koşulları, ondan sonra aile hekimleri üzerine eklenen angarya işler, eee, çalışma koşullarını gittikçe bozuyor. En son işte bu cumartesi nöbetleri... Tamamen baskıcı bir yönetim uygulanıyor. Dünya çalışma örgütünün, Avrupa insan hakları mahkemesinin verdiği kararlara aykırı olarak, bizi fazladan sekiz saat çalışmaya zorluyor. Bizi şu anda en rahatsız eden olay budur. Nöbetlere kalmıyoruz, direniyoruz şu anda.

[35] Hastanın öyle bir talebi yok ki, biz burada kaç zamandır, cumartesi bir kaç kez açtık, bir tane hasta bile gelmedi. Çünkü hastaların buradaki hastaların öyle bir beklentisi yok. Öyle alışmışlar zaten, acilsen acile gidersin zaten. Burada böyle bir popülizm var. Yani bakın size cumartesi doktorları ayağınıza getirdik havası.

[36] Sağlık Ocağı'nda hasta gelirdi, müsait olan hangi hekim varsa onla görüşürdü. İstediği doktoru seçemeyebiliyordu, sıradan ötürü. Aynı hasta, başka hekimlerce görüldüğü için, doğru düzgün bir takibi yapılamazdı ama Aile hekimliği sistemi, böyle bir takibi başlattı. Artık hastayı takip etme şansın var, nüfusa aşina oluyorsun. İstemeyen memnun olmayan değiştirebiliyor, iletişim anlamında daha doğru bir ilişki kuruluyor.

[37] Tabii gözlemliyoruz. Çünkü her hastanın bir hekimi var artık ve hep aynı hastalar geldiği için, bir hekim hasta ilişkisi daha rahat kuruluyor ister istemez. Sağlık Ocağında bu çok

mümkün olmuyordu. Hasta geliyordu, bilgisayar ya size verirdi ya başka hekime verirdi, onun özel bir şeyi yoktu. Yani dolayısıyla, bu kadar sıkı hasta hekim ilişkisi kurulacak ortam yoktu.

[38] Bu sisteme geçildikten sonra, Sağlık Ocağından en temel fark, kurulan duygusal bağ. Eskiden, hastayı eve getirdiğimizde unutuyorduk. Şimdi duygusal bağ kuruyoruz, bir şey olduğunda, öldüklerinde üzülüyoruz.

[39] […] bunda iyi taraf, size kayıtlı olan kişiler var, sadece onlarla muhatap oluyorsunuz ve hani süreklilik olabiliyor hani, takip edebiliyorsunuz, sağlık kayıtlarını tutabiliyorsunuz. Hasta açısından da, sizin açınızdan da daha iyi hani bir güven de oluşuyor ve bilgi aktarımı daha sağlıklı oluyor. Bir giden bir daha gelmez olmuyor. Bir daha geldiysen atlanan bir şey varsa, ikinci üçüncü gelişinde tespit edebiliyorsunuz, bu daha iyi o açıdan.

[40] 75-76lı yıllarından bahsediyorum ben, o zamanki yıllarda doktorluk daha revaçta bir meslekti. Daha saygın, halk arasında da daha saygı gören, sevilen, insanların doktorlara yaklaşımının çok daha iyi olduğu, doktorlara daha ne bileyim değer verildiği bir durumdu. Şu anda öyle değil maalesef. Şu anda doktorlar, işte medyada da gördüğünüz gibi saldırılara uğruyorlar, darp ediliyorlar. Saygı zaten saygı kelimesi artık hiç bahsedilmeye bile gerek yok yani gelen kişilerin istediği doğrultusunda herhangi bir şey yapmazsan her türlü kötü muameleye muhatap olabiliyorsun ve yöneticiler yani eski yöneticiler gibi değil, bizim mesleğin arkasında kimse durmuyor. Gelen kişilerle, halka çok iç içe olan bir meslek direk ilişkide olduğun kişiler olduğundan dolayı, en ufak bir anlaşmazlık durumunda olaylar büyüyebiliyor yani, büyüyor da.

[41] Son yıllarda, yani özellikle şu andaki hükümet diyelim veya devlet anlayışı, bunu çok daha kötüye getirdi. Son 10 yıldır falan daha kötü.

[42] Yani bizim burada en çok karşılaştığımız şeyler, hastaların özellikle buradan hizmet alma hakkına sahip olmayan hastaların, haklarını bilmemeleri. Neye hakkı olduğunu bilmiyor. Özet veriyorum, geliyor, bizden ilacı için rapor çıkarmamızı istiyor. Uzman aile hekimi rapor çıkartabiliyor, geliyor benden istiyor. Senin aile hekimin nerede? Beşiktaş'ta. E, ben rapor çıkartmak istiyorum, siz çıkartamaz mısınız? Çıkartamam, aile hekimi ben değilim çünkü. E, siz olun o zaman aile hekimi? Bir tek rapor çıkartmak için niçin aile hekimini değiştiriyorsun? Git hastanede çıkar diyorum, kızıyor bize.

[43] Buraya gelen herkese rapor vermek zorunda değiliz. Böyle bir algı var. Vermediklerimiz öfkeli ayrılıyor. İş yerinde maaş kesintisi oluyor ama hakikaten çok da hasta olmayana rapor vermek istemiyorum çünkü ben de çok hastayken çalışıyorum/çalıştım yani. O yüzden insanlarla papaz oluyoruz yani.

[44] […] çok memnun ayrılan da var. Dediğim gibi hastanın beklentisi önemli. Örneğin hasta buraya rapor almaya geldiyse, sizin tedavinizin güler yüzünüzün hiçbir önemi yok. Hastaya siz rapor veririm dersseniz, ondan mutlusu yok ama rapor vermem derseniz, hasta küfrederek gidiyor. Bazı hastanın kişiliğine bağlı, beklentisine bağlı, moduna bağlı.

[45] 6 yıldır mesela benim hastam, adam haftada bir geliyor. Adamı biliyorum, e şimdi kimliği yok yanında, suç. Ama adamı tanıyorum, eve gitse alsa getireceği kimlik aynı kimlik, bir şey değişmiyor. Bakamam diyorsun, öyle deyince kırılıyor, küsüyor. Bazısı inat, kavga ediyor. Anlatamıyorsun kimliksiz bakılamıyor diye. Hadi bu sefer bakıyorsun, e bir korku var. Sigortadan müfettiş içeri girse, adamın kimliği yok, boku yersin.

[46] O zaman şey havasına sokuyor, senin inisiyatifinde de sen yapmak istemiyorsun'a getiriyor işi. Oysa aslında hukuksal anlamda o yanlış yapılan bir şey. Evet, ben inisiyatif kullanarak ben onu halledebilirim belki ama bu hukuksal anlamda beni sıkıntıya sokabilir bir, ikincisi etik olmayabilir. Başkalarına yapmayıp da buna yapmam çok doğru olmayabilir, kendi vicdanım

açısından rahatsız edebilir - gibi bir takım sosyal olgular da işin içine giriyor ama tabii genel kanı böyledir tabii.

[47] Bütün işlerini burada yaptırmıyorlar çünkü. Hepsinin hemen hemen gittiği özel çocuk doktorları var. Kadın doğumcuları var ya da bir şey olduğunda, özel sigortalı olduklarından özel hastanelere gidebiliyorlar. Bize sadece işte ilaçlarını yazdırmaya, işte ne bileyim ufak tefek rahatsızlıkları için. […] Burayla sadece devletin yapmakta zorunlu olduğu işleri açısından gelmek zorunda oluyorlar.

[48] Performans sisteminden şöyle memnunum, bazı hekim ve hemşire arkadaşların işleri doğru yapabilmesi için performansa tabii olmaları gerekiyor. Bizde performansa dâhil olan bölümler daha ziyade hasta muayenesi falan değil de, gebe takibi, bebeklerin aşıları ve 65 yaş üstü hasta. Takibi. Performans kesintileri de çok yüksek. Bir gebe takibini kaçırırsanız, 250 lira civarı, aşıyı kaçırırsanız 500 lira civarı paralar kesiliyor. O yüzden herkes dört elle bu işe sarılıyor ama kişinin insafına bırakılırsa bu kadar takip yapılmayacaktır diye düşünüyorum, eski sistemi bildiğim için yani.

[49] Popülist politikalarla birlikte, bireylerin kendisinde olması gereken yükümlülükleri sizin üstünüze atıyorlar. Nasıl atıyorlar? Şöyle atıyorlar, şimdi sizin çocuğunuz doğuyor. Bizim şeyimize düşüyor, bilgisayarımıza. Çocuğun aşıları olacak, biz bu çocuğu takip etmek zorundayız, sizin hiçbir sorumluluğunuz yok, bütün sorumluluk bizde.

[50] Şöyle yaşıyoruz, bize gelmedikleri için telefonla irtibat kurma mecburiyetindeyiz. İşte bize ihtiyaçları olmayınca, telefonumuza da bazen cevap vermek istemiyorlar. Mesela açıyoruz, ben diyor sizin sağlık ocağınızdan faydalanmak istemiyorum ki diyor beni niye arıyorsunuz diyor. Biz de diyoruz ki bu sizinle alakalı değil sadece, Bakanlık bizden istiyor. Bizim sizi takip etmemiz gerekiyor, onun için arıyoruz. 'E ben almıyorum kardeşim, beni niye ilgilendirir', bir mecburiyet hissetmediği için.

[51] Dedektif gibi hekimin hastayı araması isteniyor. Peşine düşeceksiniz, gerekirse evine gideceksiniz. Evine gidiyorsun, adam sana kapıyı yüzüne kapatıyor, diyor ne işiniz var burada diyor yani diyor.

[52] Bazı hastalarımıza hiç ulaşamıyoruz yani çünkü hakikaten çok yüksek sosyoekonomik düzeyi ya da işte ünlü oluyor, onlara ulaşmak çok mümkün olmuyor hiç bir türlü. Telefonunu bulamıyorsunuz, bulsanız yardımcıları işte şey yapmıyor, izin vermiyor onlara ulaşmamıza. Öyle sıkıntılar.

[53] Biz başvuru yapana hizmet verirdik. Diğerlerini aramazdık herhâlde. Düzgün işler miydi bu izlemler, pek sanmıyorum yani. Sahayı biliyorum çünkü. Ama negatif değil de pozitif performans olsaydı, yine düzgün işlerdi. Şimdi daha böyle insanları tüketerek ilerliyor. Diğeriyle daha güzel ilerleyebilirdi.

[54] Yani yüzde doksan gereksizdi. Haklı olanlar da var, tabii olması gerekiyor. Sahayı görmek için alo şikâyet hattının olması gerekiyor, hani herkes iyi değil; herkes iyi niyetli davranmıyor.

[55] Hani bunun bir yaptırımı da olmalı, yalan beyanın haksız yere şikâyette. Çünkü bu motivasyonu da kırıyor, muhatap olmak bu tür şikâyetlerde. Ee, olması gerekiyor ama hastaların, haklarını bildiği kadar hadlerini de bilmeleri gerekiyor.

[56] İşte, sistemin işleyişini bilmeyip, yukardan da aldığı mesajla, işte ne yapmak istersen yapmak zorundalar mesajıyla 184e başvurduğunu düşünüyorum şu an.

[57] Her şeye hakkı olduğunu zanneden ama neye hakkı olduğunu bilmeyen bir kesim burası.

[58] Toplum Sağlığı Merkezi tabii çok seviyor, bizim aramız bozuk ya, bir baktım hop damladılar. Hiç böyle ışık hızıyla geldiler. Yaptıkları şey, benim o saatte hasta bakıp bakmadığıma bakmak. O gün de 12'yi 15 geçeye kadar hasta bakmışım, iyi dediler gittiler.
[59] Geliyorsunuz bu saatte hasta bakılmış mı bakılmamış mı diye bakıyorsunuz. Hâlbuki sizin

yapmanız gereken niye burada biz 12yi 15 geçeye kadar hasta bakılıyor. Niye bu kadar çok yoğunluk var, neden böyle oluyor diye araştırmanız lazım. Bu bizden kaynaklanabilir, bölgeden kaynaklanabilir. Yani sizin maksadınız?