أنطباعات أطباء الأسرة المقيمين الأقدمين حول مفهوم أختصاصهم وتقييم المنهاج التدريبي لطب الأسره في العراق

رسالة

رسالة مقدمة الى مجلس كلية الطب – جامعة كربلاء كجزء من متطلبات نيل شهادة الدبلوم العالي في طب الأسرة

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Republic of Iraq

Ministry of Higher Education

& Scientific Research

University of Kerbala

College of Medicine

Family Medicine Resident's Perception about their Specialty and Residency Program Assessment in Iraq

A dissertation

Submitted to the council of the College of Medicine / University of Kerbala as partial fulfillment for the degree of Higher Diploma in Family Medicine

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بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

وَمَا تَوْفِيقِي إِلَّا بِاللَّهِ عَلَيْهِ تَوَكَّلْتُ وَإِلَيْهِ أُنِيب(٨٨)

صدق الله العلي العظيم

هود

Supervisor Certification

I certify that this thesis (Family Medicine Resident's Perception about their Specialty and Residency Program Assessment in Iraq) was prepared under my supervision in the department of family community medicine as a partial fulfillment of the degree of Diploma of Family Medicine.

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/ / 2019

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/ / 2019

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/ / 2019

Dedication

Every person in my beautiful family especially my father and my mother (are the greatest gifts GOD has given me) who stay all the time from my childhood till now leading me to the right way and the importance of success. My husband my sister my brothers

The last one and forever will be in my mind, my best friend Dr. Safa khaleel who I lost her this year.

Thank you for being there

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Allah, most gracious, most merciful.

First of all I want to thank Allah for granting me the strength, inspiration, and light to my mind and my heart to complete this project.

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Thanks for all

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Abbreviations:

Abbreviations	Full text
AAFP	American Academy of Family Physicians.
Et al	Et alia (Latin)
FM	Family Medicine
FMR	Family medicine residents
GP	General Practitioner
Max	Maximum
Min	Minimum
MOH	Ministry Of Health
PHC	Primary health care
SD	Standard deviation
SPSS	Statistical package for social sciences
USA	United States of America
WHO	World Health Organization
WONCA	World Organization of Family Doctors

Abstract

Background:

Family Medicine specialists are the frontline of medical services. So they require a wide range of knowledge, practice and experience. Exposure of Family Medicine resident doctors to common health problems seen on daily basis is mandatory. However, the training of residents varies among various training centers, because of the variability in number of patients attending hospitals and their health problems, age, gender, and other factors.

A periodic evaluation of family medicine residency training and the exploration of residents' perception toward their specialty and training are important.

Objective of the study:

1. To explore family residents'perception toward their specialty.
2. To assess factors affecting clinical training of family residents in teaching centers.
3. To evaluate satisfaction with the FM training program and approached potential strategies for improvement from the residents.

Subject and Method:

A cross sectional study was conducted through a convenient sample covering several training centers in Iraq in the period between 1st February to 31th July, 2018. A special self-administered questionnaire based on 5 points Likert scale prepared for this purpose and was tested by a pilot study. A total of 275 questionnaire forms distributed to Family Medicine residents.

Results

The accomplished sample was 187 participants, female represents 93% of them. Nearly 55% of the participants will choose Family medicine specialty again if time is back. A similar percentage will recommend Family Medicine for students seeking advice. Nearly 75% of the participants have positive feeling towards their future as family physicians. However, 63.6% were dissatisfied with their residency training program. Lack of adherence of teaching hospitals to training curriculum, on different areas, and this indicate weak understanding and acceptance, to them and Family Medicine specialty from physicians of other clinical branches.

Conclusions:

Despite the general dissatisfaction among Family Medicine residents because of the obstacles faced by the training program, there is good proportion of residents who were satisfied with family medicine specialty as a chosen career; but they have many critiques concerning their residency training curricula and the application of clinical training in the hospitals. These points are vital and need to be considered by their supervisors and higher committees concerned. We suggest that the Ministry Of Health need to define an obvious career lines for residents with adequately organized program in the future.

Chapter one Introduction

Family Medicine is a medical specialty which provides continuing, comprehensive health care for the individual and family (1). It integrates a broad-spectrum approach to primary care with the consideration of health-impacting social determinants and community factors. While also serving as an advocate for the patient in an increasingly complex health care system. Unlike other narrowly focused specialties family medicine includes the biological, clinical and behavioral sciences. Encompassing all ages, sexes, each organ system and every disease entity (2).

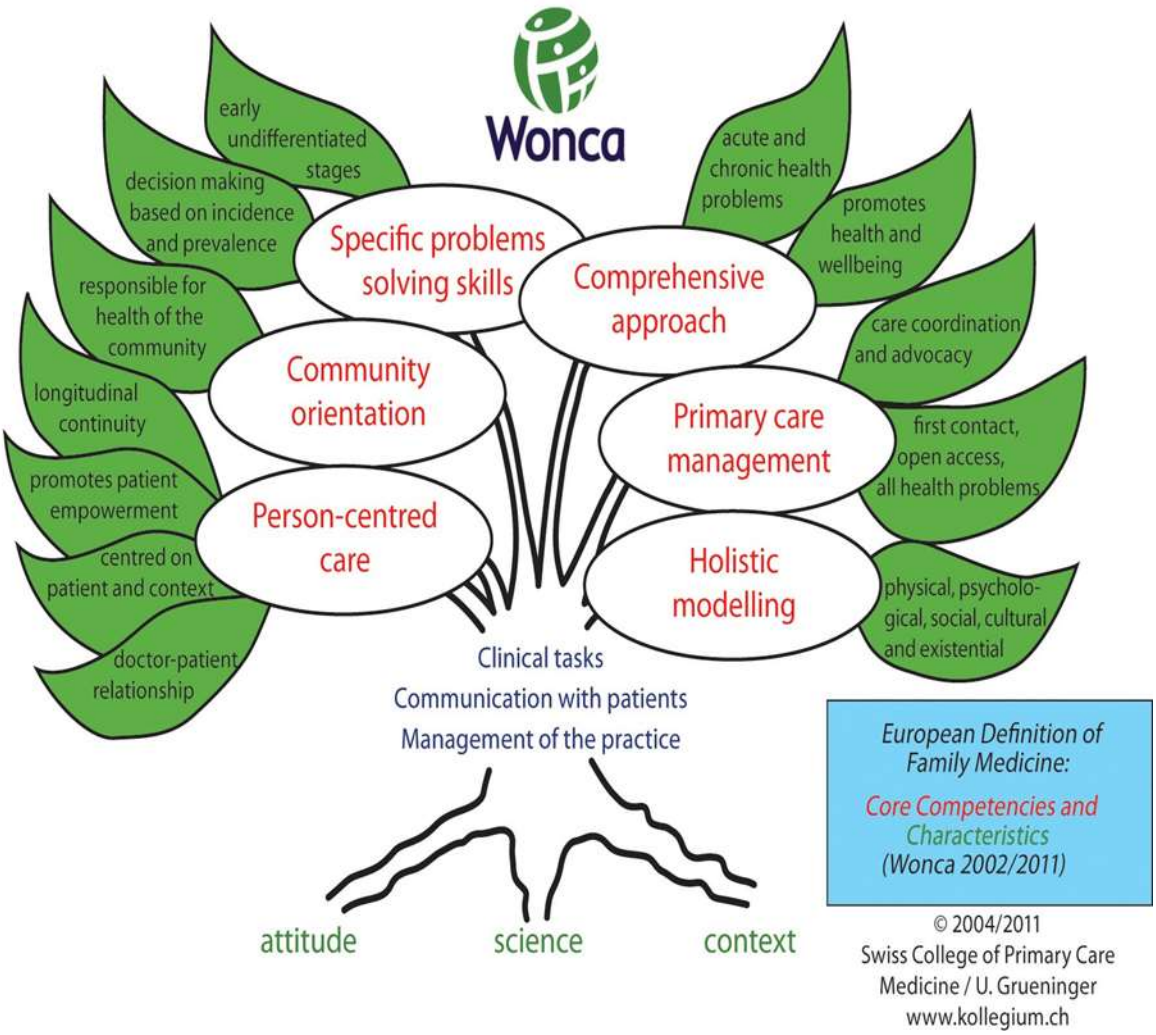
All over the history of family medicine the intellectual differentiation between generalist and specialist has created a great division. This contrast has been played out in the distinction between family doctor, the new breed of specialist versus general practitioner, and the old guard (3).

The World Health Organization (WHO) emphasizes on achieving equitable access to health for all, so in the 2008 World Health Report reminded the world that primary health care was needed 'Now More Than Ever'. Leadership and public policy reforms are needed in order to achieve the universal coverage and realizing that the primary care represents the heart of health service delivery that 'puts people first' (4). The first point of entry into the healthcare system for most patients is represented by primary care (5). Health has been the center of social, economic, political and cultural development in all human societies and has a particular importance in infrastructures development in different sections of country (6). It is necessary to apply four fundamental principles of the country's (Health and Treatment Network); institution social equity, community participation, intersectional collaboration and using appropriate technology in all phases of running the Family Physician Program; These principles lead to

success of primary health care (PHC) program in the form of a system of health care networks in the country (7). Researchers have demonstrated that health systems with strong primary care basis are known to improve overall health outcomes at less cost and have more capacity to reduce health disparities than specialty-centered care systems. If we want to realize the national vision for health we must begin to rebuild the primary care physician workforce in order to provide "the provision of timely, appropriate, comprehensive, patient-centered care for all people at a cost they can afford" (8). One of the most important duties of family doctor is to provide services and primary health care. Without providing such services using family physician term to provide merely medical services is inappropriate (7).

The challenges facing Family Medicine are expanding in the developing countries, where the limited funds for health care are often devoured by hospital and specialty centers (9), because medical curricula are often hospital-based and there is little emphasis on community-oriented activities, prevention, doctor – patient communication and teamwork. So it is not surprising that family medicine is not only "the great unknown" within the faculty; Several reports suggest that there is a tendency for both seniors and students to undervalue family medicine (10).

At the Alma-Ata Conference on Primary Health Care in 1978, the World Health Organization (WHO) declared that the primary health care is the key to 'health for all by the year 2000'. Unfortunately the role of family medicine was not clarified (11). In a joint WHO–WONCA conference in 1994, WHO formally approved the contribution of FM to medical practice and education. The 62nd World Health Assembly In 2009 urged its member states to train and retain adequate numbers of health workers, including family physicians and to foster the application of vertical programs in the context of integrated primary health care (12).



THE WONCA TREE – AS PRODUCED BY THE SWISS COLLEGE OF PRIMARY CARE

Why family Medicine is so important?

- Improves overall health**;** clients who regularly visit a family physician are more likely to receive preventive services, better management of chronic illnesses and reduce chance of premature death.
- Plays an important role in access to health care**;** Family physicians are geographically distributed across the country more equitably than physicians from any other specialty.
- Helps to decrease health disparities**;** Family physicians are more accessible geographically and financially to underserve communities lacking access to quality health care than other primary care physicians.
- Decrease health care costs and increases health care quality (2).

So, the family doctor is the base of the most successful health care systems (9) and he must become the axis around which health needs are accommodated to, together with social conditioning factors that affect families and individuals. This leads to a trans-disciplinary approach to communities set free from a mere biomedical profile (13). Therefore, family medicine is considered compulsory for effective health service delivery. To a chief a desirable change in health and healthcare delivery in the country strong leadership in the specialty of family medicine is required. It is believed that a key for the discipline's growth represented by efforts to train future leaders (14).

The specialty of Family Medicine is considered a frontline and it is a demanding one; it requires a full range of experience, practice and knowledge(15). An optimally trained workforce to deliver primary care to patients, families and communities is the ambition of family medicine education (16).

A critical point to the care of many patients is collaboration between family physician and other specialists, because this could affect the effectiveness of primary health care delivery on daily basis (17). Teamwork is essential and is required for the benefit of patients which occurs across a complex net of inter-professional cooperation and services (18).

Residency is an exciting and important time; The final step in our way to independent practice is the exposure of family residents to common health problems seen in the ambulatory care setting is mandatory (19, 20) , to provide comprehensive, continuous care for patients of all ages. A critical part of this education is learning how to access the best evidence at the point of care, to manage and apply information, and to use resources efficiently (21).

The residency program of FM is unlike other specialty residency programs; a major part of the family medicine training is rotating training in different medical specialties. However, family medicine-specific training is regarded more important than rotation in various specialties. The role of family physicians should not be limited, their role has expanded from the existing disease-oriented paradigm to the patients, family and community-oriented paradigm and the range of medical care included counseling of health risk factors, health education, preventive medicine and disease management (22).

Family medicine residency program was established for accreditation of general practice and exit from crisis after physicians' tendency to especialize in USA 1969. It was introduced as the axis of the world attempts for improving quality, cost-effectiveness and equity in health care system; In spite of early successes, the program was faced with challenges through the time. FM was recognized in the USA in 1969 as the 20^{th} medical specialty board (23). FM has developed slowly compared to other clinical medical specialties in most Arab countries (24).

In Iraq Council of Family Medicine was established in 1995 in association Community Medicine, the first graduated group in 1999. Four years of postgraduate training (theory & clinical), including a thesis or Dissertation (25). In 2006 a residency training was established in the MOH (ministry of health) for Family Medicine (26). Center for the Arab Board of Family Medicine started in 2007 (27).

The AAFP is obligated to ensuring high-quality, inventive education for residents and medical students that incarnates the premium and competencies of family medicine (28).

However, training of residents varies among different training centers. This related to the variability in number of patients attending to hospitals and their health problems, age, gender, socioeconomic level, educational level and so many factors. In order to cater the demands of the community, it is necessary to continuously evaluate residents' training (19, 29-31).

The objective of family medicine residency programs is to provide training that will promote in their learners' motivations for life-long learning, including the understanding that the training period is only an initial invasion into developing the required competencies (32) and it is essential before independent primary care practice (33).

It is important to consider factors influence medical students' decisions to incorporate to their residency programs for optimal recruitment and train future physicians (34). A correct insight of medical students in job career choices is necessary. The inclinations of medical students to their clinical job and final specialty is a consequence of a balance between personal preferences, clinical experiences and job status (35).

Understanding the factors that influence family residents' training is crucial in order to prevent possible family physicians' shortage in the future (36).

According the literature, physicians are the most influential factors of the health system and their performance plays a key role in the success of any health sector reform plans (37). Job stress is closely related to job satisfaction. Job satisfaction is multifactorial which determined by many factors such as the organization of healthcare and patients' attitudes about physicians (38).

Job satisfaction is defined as a pleasurable or positive emotional state, resulting from the appraisal of one's job or job experiences. It is the result of complex interactions between the work experience and the organizational environment (39).

Since the primary care level is responsible for providing medical care to a greater proportion of the population than any other care level, the job satisfaction of the family physician is a critical factor for health systems as they represent the primary care workforce (40).

High job satisfaction amongst doctors was associated with improved doctor-patient relationship and better quality prescribing, higher level of medication adherence and lower level of dissatisfaction among patients (41). So, doctors satisfaction has not only a bearing on the doctors themselves but also on the patients as well (42). Doctors' job dissatisfaction is associated with un preferable consequences such poor doctor–patient communication and quality of care below the required level (43).

Objective of this study are:-

1. To explore family residents'perception toward their specialty.
2. To assess factors affecting clinical training of family residents in teaching centers.
3. To evaluate satisfaction with the FM training program and approached potential strategies for improvement from the residents.

2-1 Study design and setting:

A cross-sectional study was conducted from the first of February to the thirty of July 2018, through convenient sample across different governorates of Iraq including (kerbala, Babylon, Baghdad and Najaf) and others like (Basrah, Ninva, DhiQar, Al-Qadisiyah, Kirkuk, Wasit, Diyalah and Muthanna). Those residents were selected to obtain their perception toward the concept of their specialty, exploring factors that affect their training in teaching hospitals and evaluate their satisfaction about training curriculum.

2-2 Data collection & Selection of participants:

Family Medicine Residents (FMR) currently practicing in any governorates in Iraq were informed and invited to participate in the study through self-administered questionnaire either by direct contact (in some governorates were visited); or online through post on facebook on specific group called (family medicine doctors) and group on telegram called (students of Iraqi & Arab Board of family medicine). Those who gave consent to participate then were sent a study questionnaire. The FMRs were requested to complete and return the questionnaire within a month. Reminder messages were sent weekly to the FRs who had agreed to participate in the study. The study included any currently resident consisting (plain permanent, students of Iraqi & Arab Board and student of Diploma). Two hundred seventy five (275) questionnaire forms were distributed to family medicine residents; only (75.6% response rate), 208 forms were collected; this was because of technical problem facing some participants who received the questionnaire online. From these 208 forms; 21 forms excluded from study because 20 were seniors and one practice his training in Jorden, so the final sample size was 187.

2-3 Exclusion criteria:

1. Family seniors.
2. Family practitioner.
3. Any resident finishing his/her training outside Iraq.

2-4 Ethical considerations:

The study was in compliance with the ministry of Higher Education University of Kerbala College of Medicine, which reviewed and approved the study. The purpose of the study was written in the first form of the questionnaires to be read by the participants before answering the questionnaire to informing them about the study protocol. Moreover, personal identifiers were not used at any point during data analysis or preparation of the manuscript.

2-5 Pilot study:

Before starting to collect information, the questionnaire was piloted on ten FMRs. The pilot study was done in one of the teaching center (kerbala) and any ambiguities found were removed, after that modification on questionnaire was done.

2-6 Study questionnaire:

After thorough search of literatures, experts' opinion and the supervisor suggestions, a structured questionnaire were developed by the researcher which prepared one of it in English and the other in Arabic. Self-administered questionnaire was composed of three sections:

- **Section one** of the questionnaire form includes demographic characteristics of the participants which include; age, gender, marital status, children number**,** living city, graduation year, teaching center and job description**;**

  a. Plain Permanent.

  b. Board 1^{st}, 2^{nd}, 3^{rd}, 4^{th}

  c. Diploma 1^{st} 2^{nd}

- **Section two** of the questionnaire form includes a close-ended questions

  - To assess the perceptions of the participants about their specialty choice and satisfaction with training program, in this section two formats:

    1. "Why did you choose family medicine?" five response options were given with two selections in front of each option (yes and no).

    2. A Likert-scale five digits were used (Strongly disagree, disagree , neutral, agree , strongly agree) this was divided in to three parts:

    - ✓ "Family Medicine career Satisfaction" includes three questions.
    - ✓ "Training and work place satisfaction" includes eleven questions.
    - ✓ "The nature of relationships and dealing during training" includes eight questions.

Mean Score Calculation

Likert's scale is an ordinal scale answers of five-point Likert's scale for areas of satisfaction were coded as: Strongly agree (very good): 4, agree (good): 3, neutral (medium): 2, disagree (weak): 1 and strongly disagree (very weak): o. Then the mean of every area was estimated.

- In order to assess residents' satisfaction with specialty two questions were mentioned. Each of these questions includes response options with two selection in front of each option (yes and no), what is satisfying you "more" and "less" about medical practice".
- To assess other consequences of satisfaction that the residents perceived; there was question: "are you interested in leaving Iraq??" three options were given (yes, no & don't know now). If answer is yes the residents were guided to give reasons for departure by seven options with two selections in front of each option (yes and no).

At the end of this section, there was question to assess residents' vision about the future of his/her medical profession? With five responses (very positive, positive, negative and very negative).

- **Section three** includes two open-ended type questions about participants' attitude toward the branch: What do you "like most" and "dislike most" about family medicine.

Finally, an open question about suggestions and/or addition.

2-7 Statistical analysis:

Data were entered and analyzed using the statistical package for social sciences (SPSS), version 25. Each participants' questionnaire was checked carefully for any inconsistency or incomplete answers, then given a specified code and transferred into computerized database. Descriptive statistics for quantitative data were presented as mean, standard deviation and range, and for qualitative data were presented as frequencies (number) and proportions (%).T test and ANOVA test were used to assess the association between overall residents' satisfaction and some variables. Level of significance was set at $P< 0.05$ as significant association. Finally, results and findings were presented in tables and figures with an explanatory paragraph for each, using the Microsoft Office Word software for windows, 2013.

❖ Description of study sample:

The results of the present study revealed that the total number of the sampled residents were 187 respondents, 14 (7%) were males and 173 (93%) were females as shown in figure (3-1); about 147 (78.6%) of participant were married whereas 39 (20.9%) were not.

The mean age was 32.43 + SD year in this study and the average number of years of services was (8.67) + SD year as it shown in table (3-1).

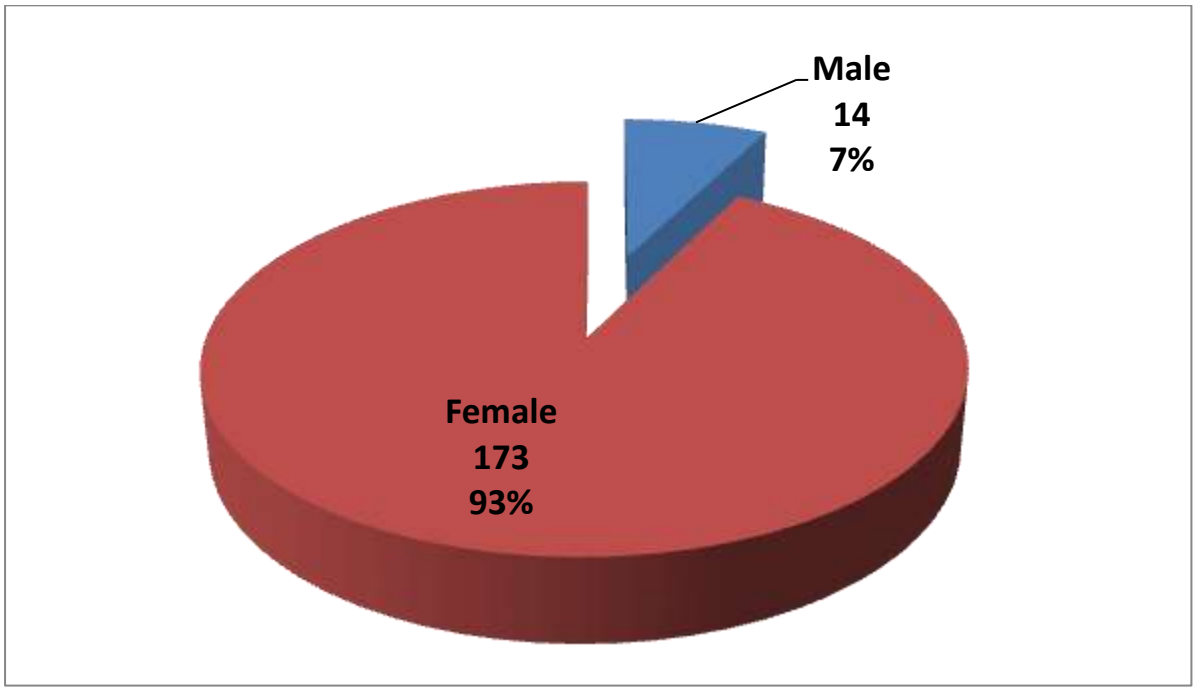


Figure (3-1): The distribution of the Family medicine residents by gender.

Table (3-1): The minimum, maximum, mean and standard deviation of age and years of services of Family Medicine residents.

	N	Min.	Max.	Mean	SD
Age\ Years	187	27	50	32.43	4.62
Years of work	187	3.00	27.00	8.67	4.42

Among 187 respondent 14 (7.5%) were permanent, 39 (20.8%) were Diploma and 134 (71.8%) were Board as shown in figure (3-2).

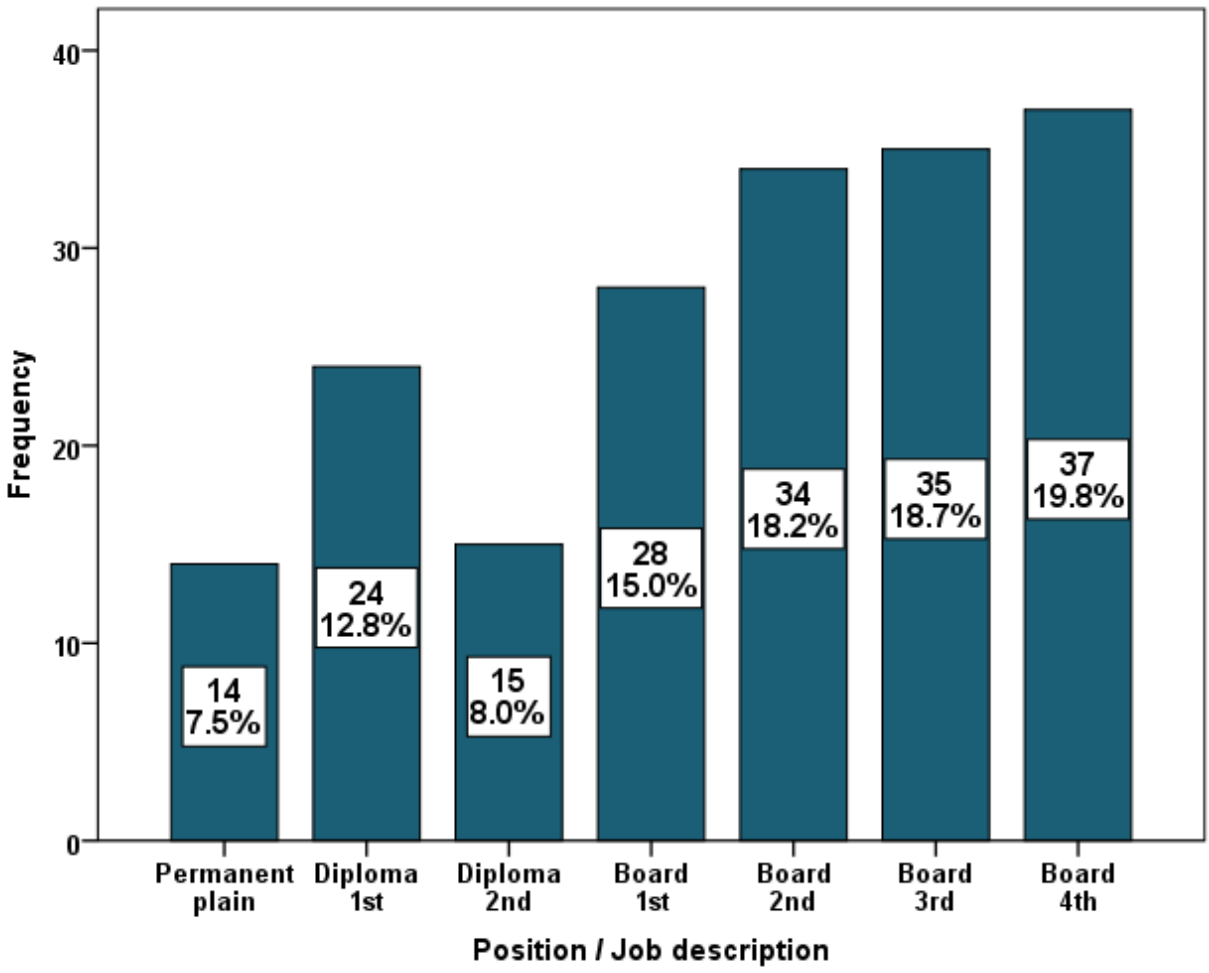


Figure (3-2): The distribution of participants according to current job description.

The majority of residents 53 (28.3%) were from Kerbalaa teaching centres, 43 (23%) were from bahgdad medical city, 22 (11.8%) residents were from Babylon teaching centres, 21 (11.2%) residents were from Al-Najaf teaching centres,18 were from Kerkh, 18 (9.6%) residents were from others, as shown in figure (3-3).

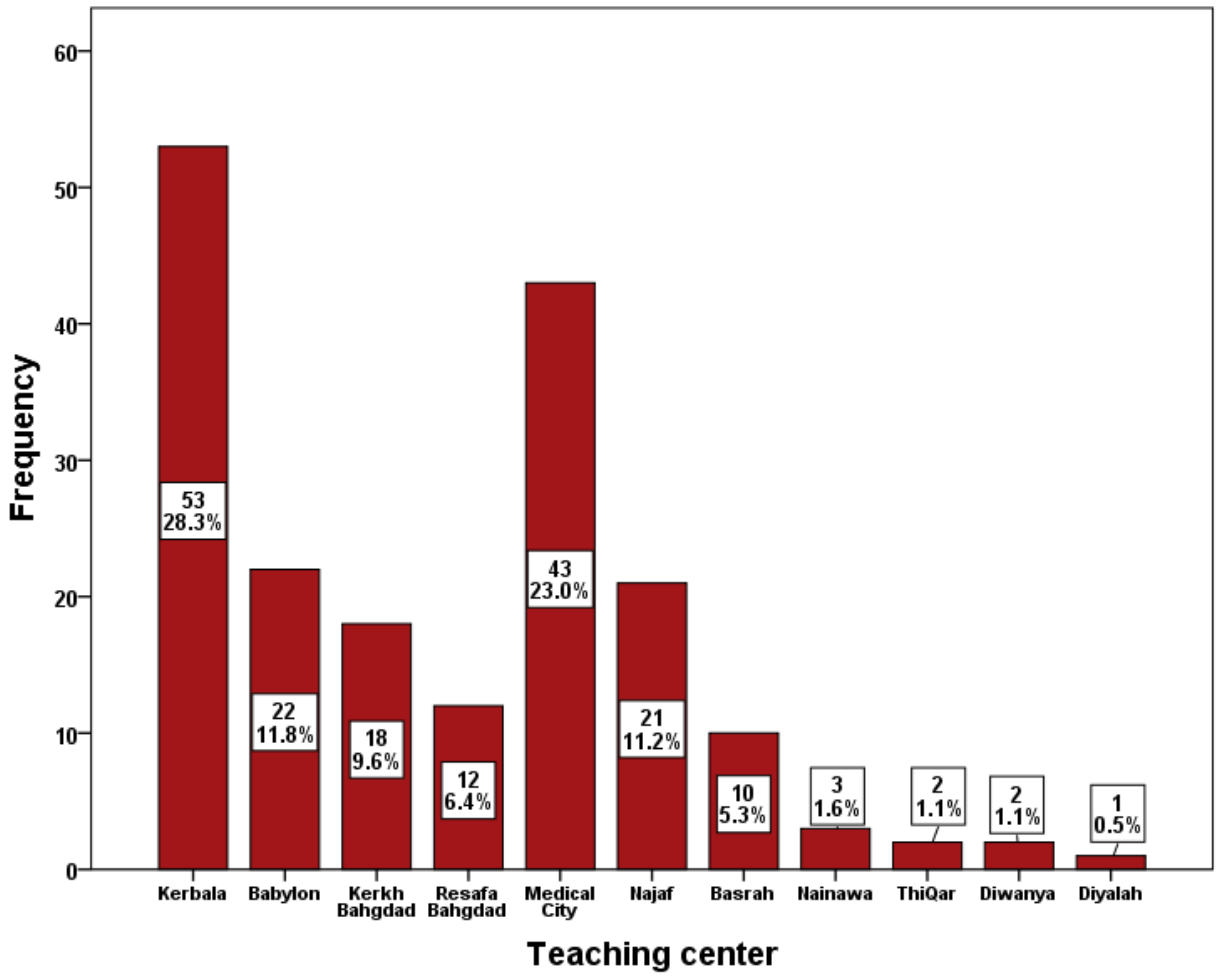


Figure (3-3): The distribution of the participants according to teaching centres.

❖ Perception and satisfaction of participants to their branch choice and training program:

Analysis of the reason behind choosing family medicine showed that most respondents replied that they can make a balance between their personal life and their work (69.5%), about (52.9%) choose less working hours and only (29.9%) replied that I'm interested. As it in figure (3-4).

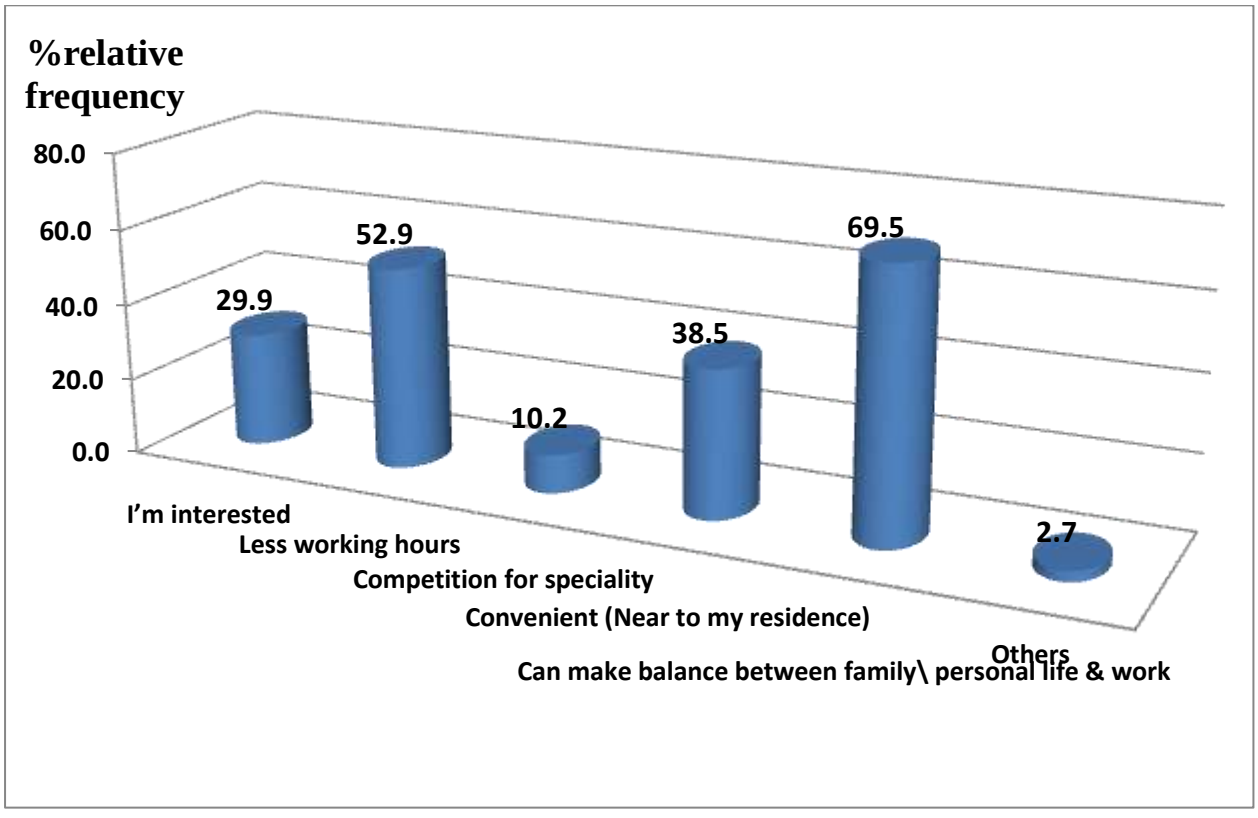


Figure (3-4): The distribution of reasons for choosing family medicine by family medicine residents in Iraq 2018.

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❖ Responses to Likert-scale Questions:

As it shown in table (3-2) about family medicine career satisfaction, (54.5%) of participants agree to choose family medicine as a career over again and same percent (54.5%) that refused the idea that family medicine no longer appeal to them. Only (21.9%) disagree to recommend family medicine to students seeking advice.

Table (3. 2): Responses to Likert-scale Questions (Family Medicine career Satisfaction).

Family Medicine career Satisfaction	**Degree of satisfaction**				
	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
If I were to start my career over again, I would choose to be a family physician	**5.9**	**19.3**	**20.3**	**32.6**	**21.9**
I would recommend family medicine to a student seeking advice.	**5.3**	**16.6**	**34.8**	**34.2**	**9.1**
Family medicine no longer has the appeal to me it used to have *	**20.9**	**33.7**	**24.6**	**13.9**	**7.0**

(*) Inverted question

As it shown in table (3-3), about training and work place satisfaction, the training program did not meet participants' expectation by about (61.0%), and about (63.6%) of participants are not satisfied with training program, (64.8%) of participants not train to practice full-spectrum FM. Only (35.8%) of them state that the time for residency is not enough. About (52.4%) state that the program did not emphasize training in performing procedures, (54%) of participants are not satisfied with adequate hands-on experience. Only (32.6%) of participants satisfied and agreed that the program trained them well to care for complex patients. About (54.6%) satisfied that they are not trained to be the principal physician for complex hospitalized patients. The participants satisfied with activities by (61.5%). The majority (86.1%) of participants stated that the training program should be more demanding.

Table (3-3): Responses to Likert-scale Questions (Training and work place satisfaction).

Training and work place satisfaction	Degree of satisfaction				
	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
My training program has met my expectations	21.9	39.0	15.0	19.8	4.3
My work in this practice has not met my expectations *	4.8	23.5	19.3	33.2	19.3
I was satisfied with my FM residency program	21.4	42.2	18.2	15.5	2.7
I was trained to practice full-spectrum family medicine	20.9	43.9	19.3	14.4	1.6
My residency trained me well to care for complex patients	9.6	31.0	26.7	28.9	3.7
The time for residency is enough to get experience	7.5	28.3	21.9	35.3	7.0
I 'm involved in different activities like researches, teaching, meetings, training	1.6	9.6	27.3	40.6	20.9
My residency program emphasized training in performing procedures	15.5	36.9	21.4	23.0	3.2
There was adequate hands-on experience	14.4	39.6	24.6	17.6	3.7
I was not trained to be the principal physician for complex hospitalized patients *	4.3	16.0	25.1	31.6	23.0
My residency program should have been more demanding	1.1	3.7	9.1	36.9	49.2

(*) mean inverted question

Table (3-4), about the nature of relationships and dealing during training showed that (74.3%) of participants had good relationship with faculty members from family & community medicine, while only (46.6%) of participants had good relationships with seniors of other specialties in hospitals. Only (26.2%) agreed that there was a supervisor in their training program in each step. About (68.4%) of participants were not satisfied with acceptance, understanding and vision of other specialties seniors about the nature of the family doctor's work. (67.4%) were not satisfied with careful follow up of senior of other specialties' to the students through the training program.

About (85%) of participants agreed that the relation with FM colleagues was good and supportive on other hand only (22.5%) of participants found good cooperation and acceptance from colleagues of other branches. (69.5%) of participants disagree when they asked "Teaching hospitals was committed to the curriculum".

Table (3-4): Responses to Likert-scale Questions (The nature of relationships and dealing during training).

The nature of relationships and dealing during training	**Degree of satisfaction**				
	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
I had good relationship with faculty members from family medicine & community medicine	**0.5**	**3.7**	**21.4**	**46.5**	**27.8**
There was a supervisor in my training program in each step	**14.4**	**33.2**	**26.2**	**19.8**	**6.4**
I had good relationships with seniors of other specialties in hospitals	**5.3**	**17.1**	**31.0**	**38.0**	**8.6**
Senior doctors of other specialties had an acceptance, understanding and vision about the nature of the family doctor's work	**27.8**	**40.6**	**23.5**	**7.5**	**.5**
senior doctors of other specialties were carefully follow up the students through the training program	**23.0**	**44.4**	**23.5**	**9.1**	**0.0**
The relation with FM colleagues is good and supportive	**0.5**	**0.5**	**13.9**	**57.2**	**27.8**
I found good cooperation and acceptance from my colleagues from the other branches	**18.2**	**26.7**	**32.6**	**19.8**	**2.7**
Teaching hospitals is committed to the curriculum	**33.7**	**35.8**	**18.7**	**10.2**	**1.6**

❖ Satisfaction of participants with specialty

- Factors that increase FMR satisfaction with family medical practice were: doctor-patients relationship (64.5%), followed by intellectual stimulation (46.0%), then (42.8%) prestige of medicine, (33.7%) interaction with colleagues and only (21.4%) financial rewards. This is shown in figure (3-5).

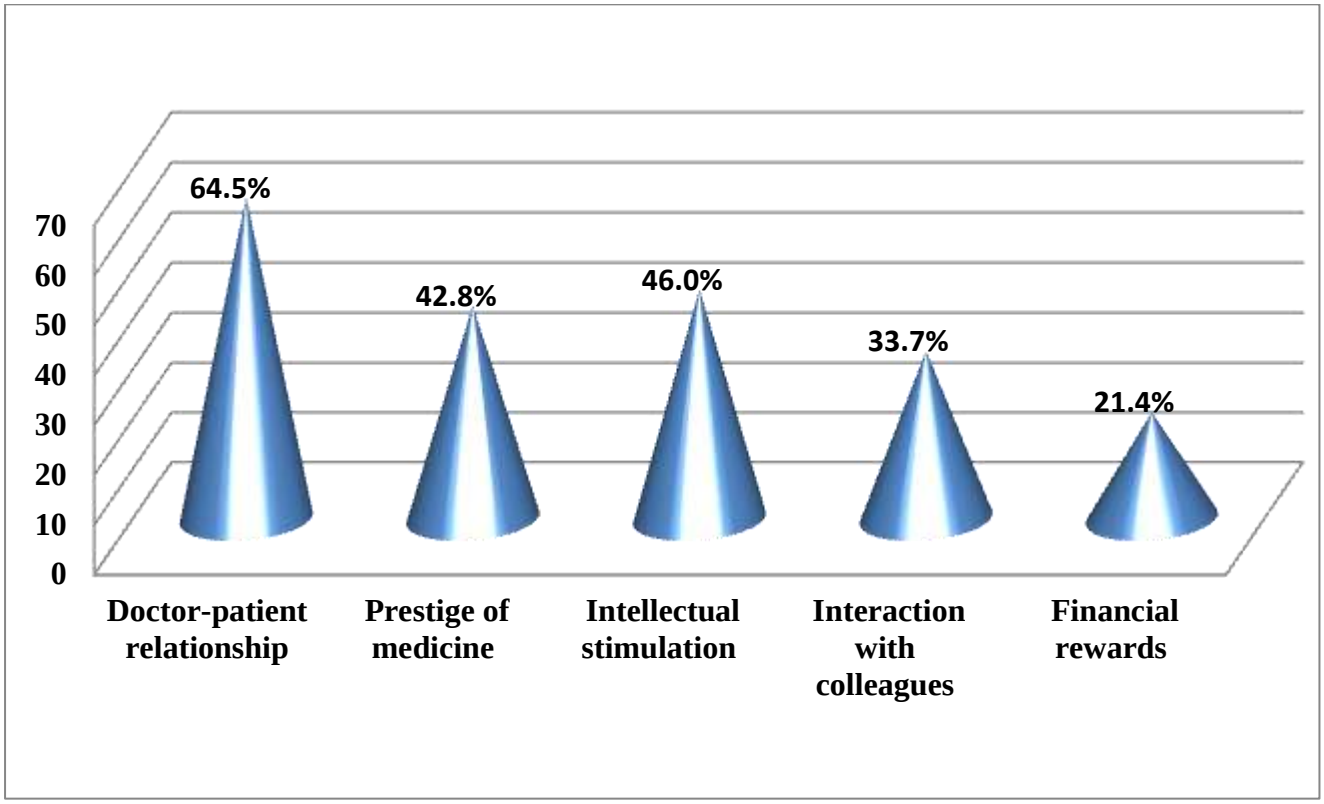

Figure (3-5): Participants factors that increase their satisfaction with family medical practice.

- While when the participants being asked "What is less satisfying you about family medical practice?" the highest rate of participants' dissatisfaction was (79.9%) pressure of current practice, about (42.8%) of participants choose lack of personal time, (29.9%) of participants choose office work and about (19.8%) dealing with medical clients. These were explained in figure (3-6).

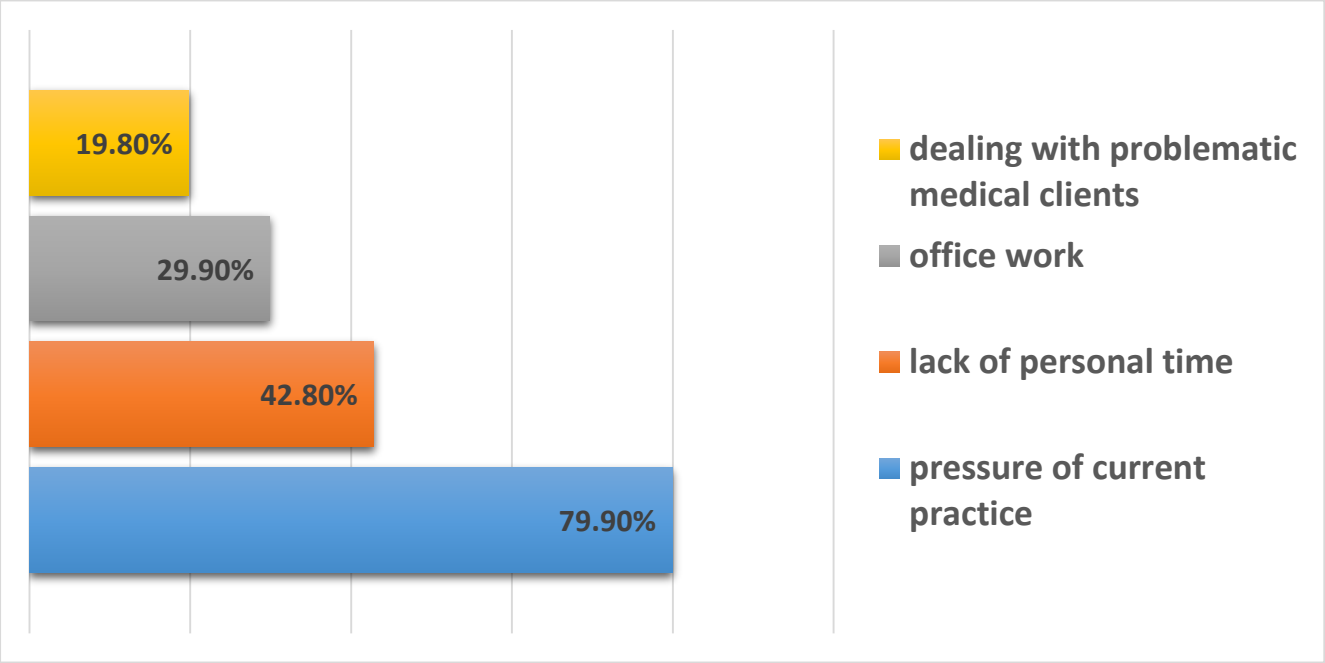

Figure (3-6): Participants factors that decrease their satisfaction with family medical practice.

❖ Assessment of other consequences of satisfaction that the residents perceived and residents' vision about the future:

Participants attitude to their branch reflected by their feelings about the future of their branch about (75%) of participants have positive feeling. While only (25%) feel negative as shown in figure (3-7).

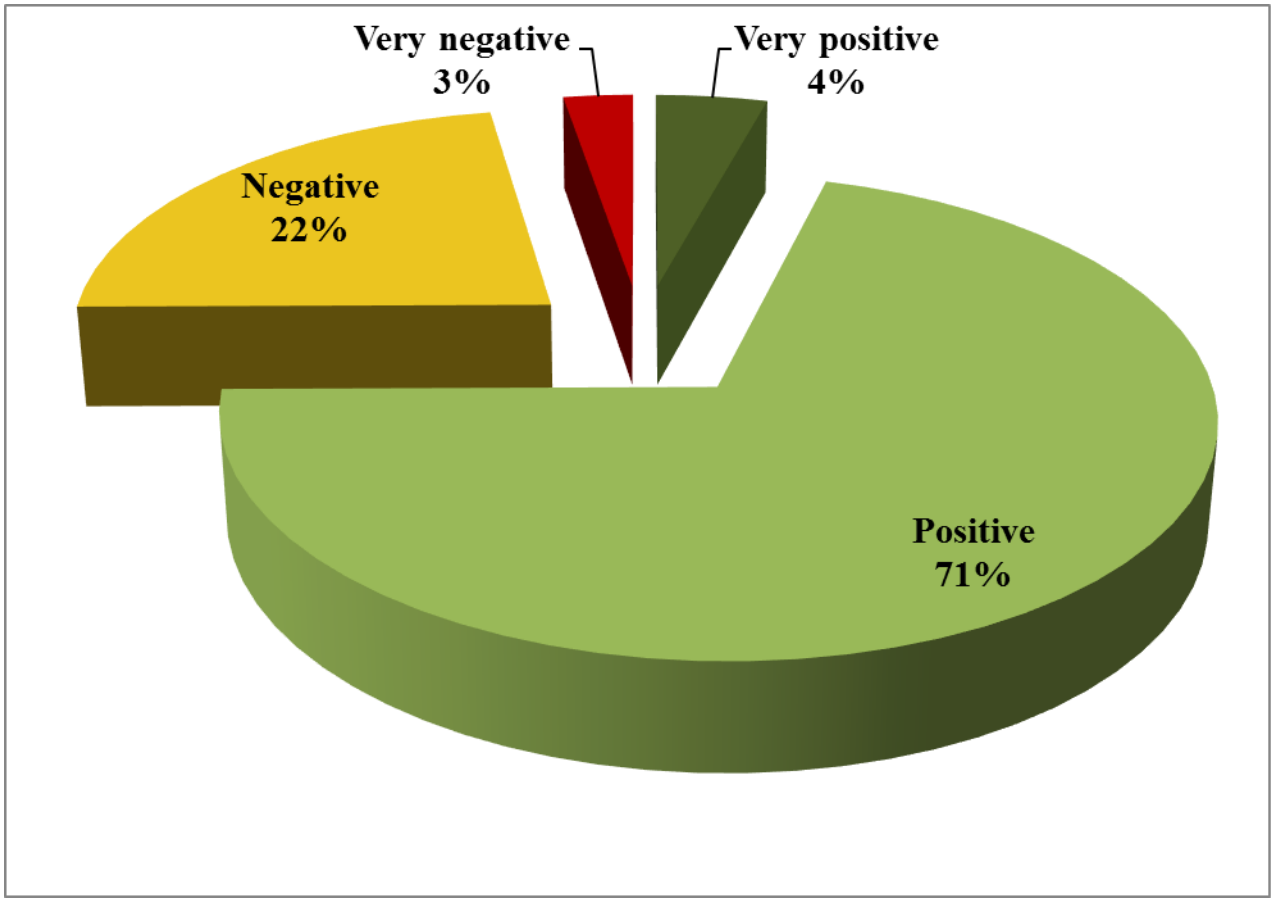

Figure (3-7): Expectations and feeling towards the future of participants' medical profession

Only (29.9%) of participants interested in leaving, Iraq this shown in figure (3-8).

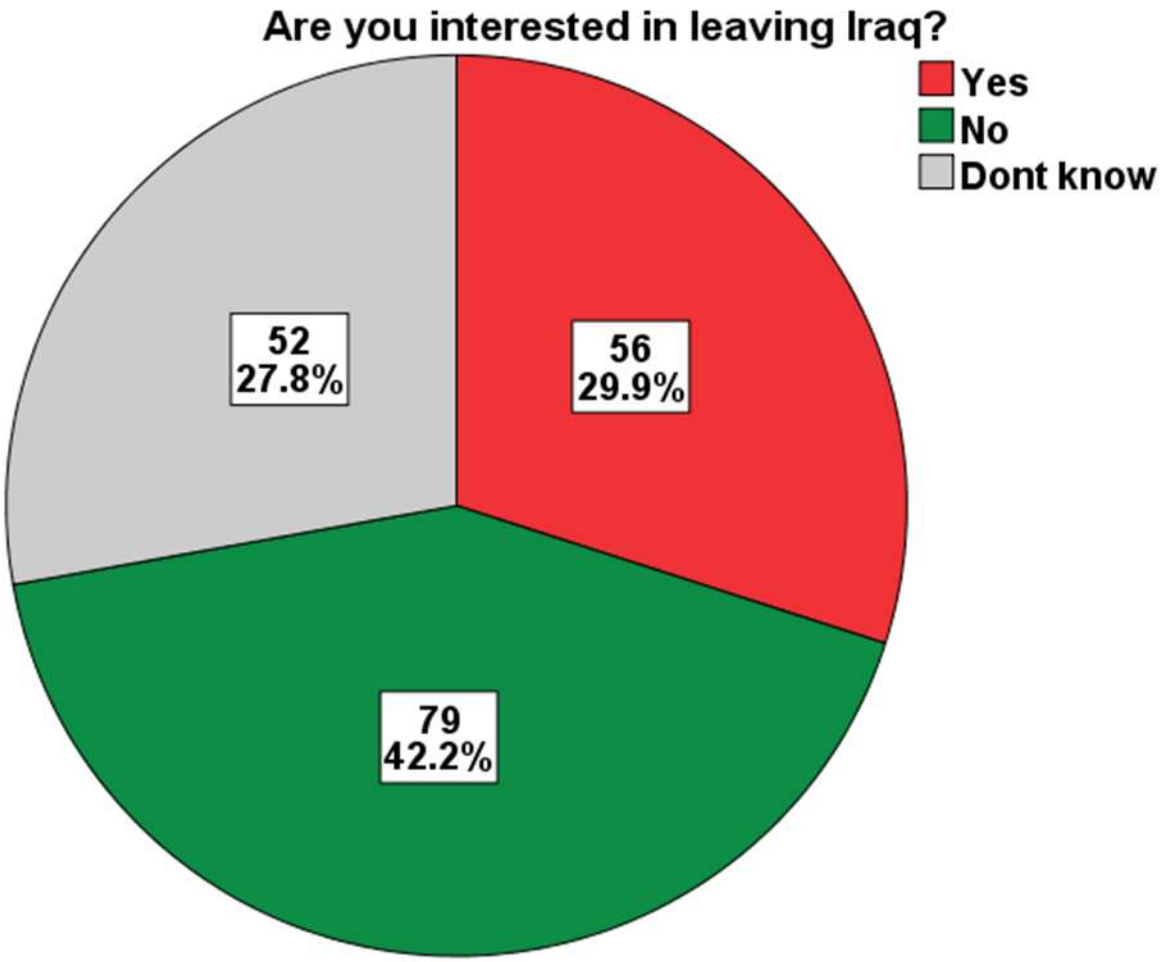

Figure (3-8): Pie Chart distribution of participants' interest in leaving Iraq.

About (23.5%) of participants selected the option (outside there is more human rights and doctor rights), and (21.9%) of participants selected the option (Threats and terrorism in my country).

❖ Responses to The two open questions:

Overall there was low response rate to these questions. But we tried to report most frequently similar answers. These include;

1. "What do you like most about family medicine?" 91 of participants (48.7%) mention because no night shift, (49) of participants (26.2%) mention because it is comprehensive, (27) of participants (14.4%) mention because of less working hours and (18) of participants (9.6%) less troubles with patients. This is shown in figure (3-9).

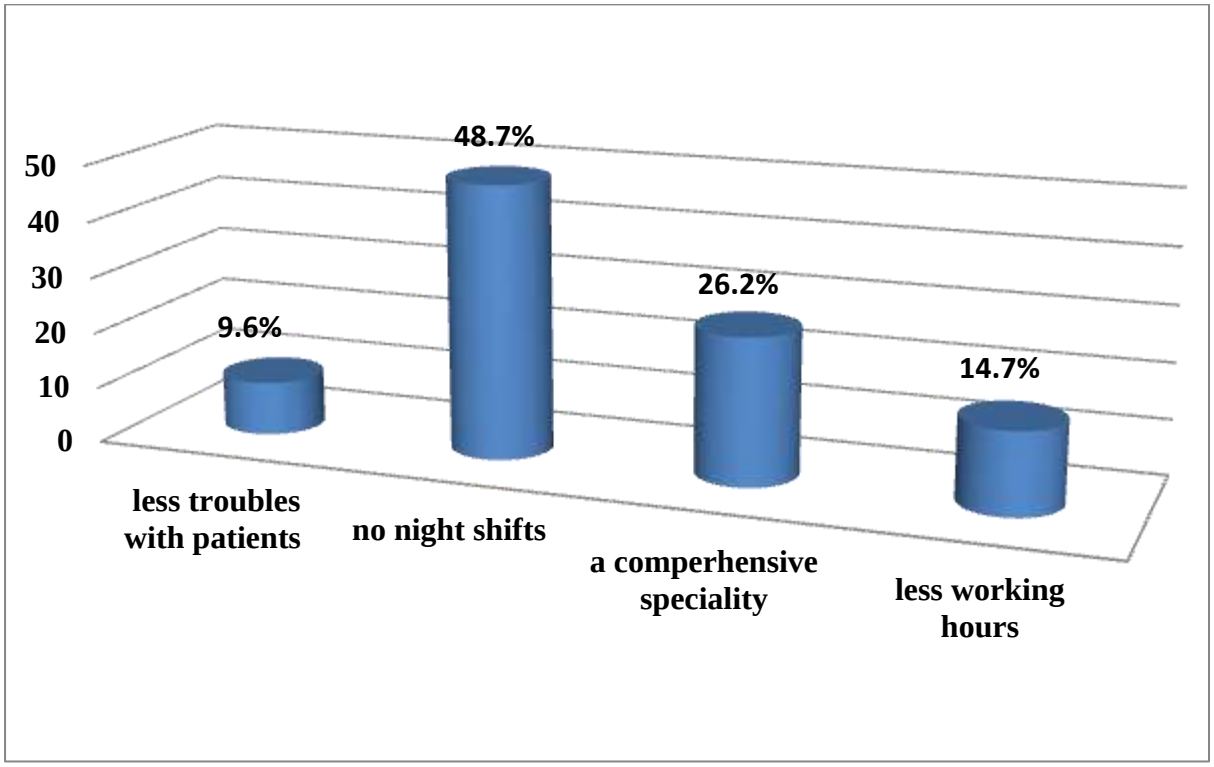

Figure (3-9): Distribution of residents according to most likely factors in family medicine.

2. Responses to most dislike factor about family medicine, shown in figure (3-8).

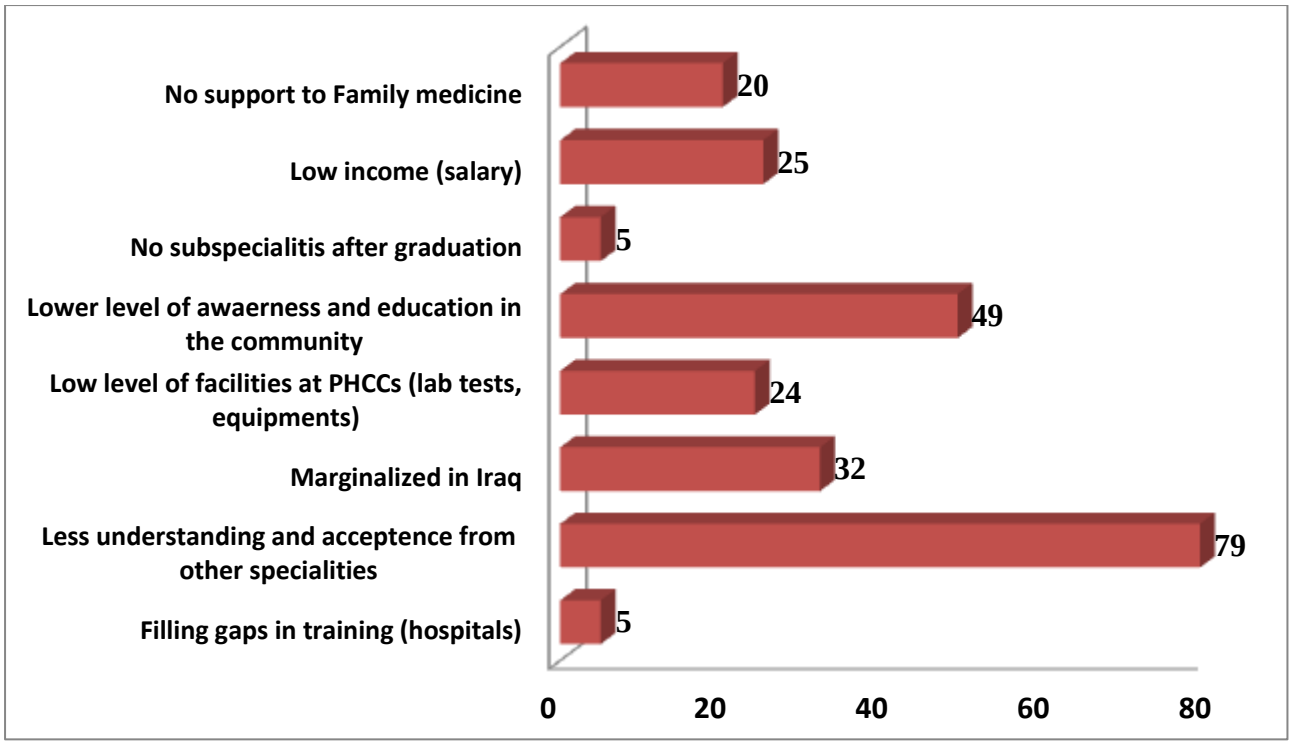

Figure (3-10): Bar chart distribution of residents according to most dislike issues in family medicine.

❖ Relationship of job description characteristics with overall participants' Satisfaction;

There were no statistical significant differences between diploma and board as it is shown in table (3-5) regarding career satisfaction, their feeling about the future of their medical professional and their interest in leaving Iraq.

Table (3-5): The participants' satisfaction according to job description (Board and Diploma) regarding Career satisfaction.

Career satisfaction		N	Mean	SD	p value
I would recommend family medicine to a student seeking advice.	**Board**	134	2.33	1.05	0.103
	Diploma	39	2.03	0.90	
If I were to start my career over again, I would choose to be an FP	**Board**	134	2.50	1.22	0.387
	Diploma	39	2.31	1.22	
Family medicine no longer has the appeal to me it used to have*	**Board**	134	1.54	1.15	0.902
	Diploma	39	1.56	1.31	
In general, which best describe how you feel about the future of your medical professional?	**Board**	134	2.22	0.55	0.691
	Diploma	39	2.26	0.55	
Are you interested in leaving Iraq?	**Board**	134	1.96	0.78	0.615
	Diploma	39	2.03	0.71	

While in table (3-6) regarding [training and work place satisfaction, the nature of relationships, and dealing during training] there were few statistical significant differences between two job descriptions; Board had higher mean score than diploma according to; expectations of FMR about training program, relationships with seniors of other specialties in hospitals, cooperation of colleagues of other branches and commitment of teaching hospital to curriculum.

Whereas diploma had higher mean score than board according to the presence of a supervisor in their training program in each step.

Table (3-6): The participants' satisfaction according to job description (Board and Diploma) regarding training and work place satisfaction and the nature of relationships and dealing during training.

Training and work place satisfaction and The nature of relationships and dealing during training		N	Mean	SD	p value
My training program has met my expectations	**Board**	134	1.58	1.16	0.005
	Diploma	39	1.00	1.05	
My work in this practice has not met my expectations	**Board**	134	2.46	1.16	0.074
	Diploma	39	2.08	1.24	
I was satisfied with my FM residency program	**Board**	134	1.41	1.06	0.083
	Diploma	39	1.08	1.01	
I was trained to practice full-spectrum family medicine	**Board**	134	1.40	1.05	0.080
	Diploma	39	1.08	0.90	
My residency trained me well to care for complex patients	**Board**	134	1.89	1.09	0.753
	Diploma	39	1.95	0.94	

The time for residency is enough to get experience	**Board**	134	2.13	1.11	0.607
	Diploma	39	2.03	0.99	
I was involved in different activities like researches, teaching, meetings, training	**Board**	134	2.67	1.01	0.682
	Diploma	39	2.74	0.79	
Continuation of table 3-6		N	Mean	SD	P value
My residency program emphasized training in performing procedures	**Board**	134	1.72	1.13	0.128
	Diploma	39	1.41	0.99	
There was adequate hands-on experience	**Board**	134	1.54	1.09	0.714
	Diploma	39	1.62	0.94	
I was not trained to be the principal physician for complex hospitalized patients	**Board**	134	2.47	1.17	0.839
	Diploma	39	2.51	1.10	
My residency program should have been more demanding	**Board**	134	3.29	0.87	0.912
	Diploma	39	3.31	0.69	
I had good relationship with faculty members from family medicine & community medicine	**Board**	134	3.00	0.80	0.730
	Diploma	39	3.05	0.86	
There was a supervisor in my training program in each step	**Board**	134	1.62	1.12	0.013
	Diploma	39	2.13	1.10	
I had good relationships with seniors of other specialties in hospitals	**Board**	134	2.36	0.98	0.026
	Diploma	39	1.95	1.10	
Senior doctors of other specialties had an acceptance, understanding and vision about the nature of the family doctor's work	**Board**	134	1.15	0.92	0.303
	Diploma	39	.97	0.96	
Senior doctors of other specialties were carefully follow up the students through the training program	**Board**	134	1.22	0.90	0.945
	Diploma	39	1.21	0.92	
The relation with FM colleagues is good and supportive	**Board**	134	3.13	0.68	0.642
	Diploma	39	3.08	0.66	
I found good cooperation and acceptance from my colleagues from the other branches	**Board**	134	1.70	1.05	0.020
	Diploma	39	1.26	1.02	
Teaching hospitals is committed to the curriculum	**Board**	134	1.20	1.06	0.009
	Diploma	39	.72	0.76	

There were only three items that show statistical significant differences among three job descriptions as it is shown in table (3-7).

Table (3-7): The participants' satisfaction according to all job descriptions

		N	Mean	SD	p value
My training program has met my expectations	**Permanent plain**	14	1.50	1.22	0.021
	Board	134	1.58	1.16	
	Diploma	39	1.00	1.05	
	Total	187	1.45	1.16	
Teaching hospitals is committed to the curriculum	**Permanent plain**	14	1.21	1.25	0.033
	Board	134	1.20	1.06	
	Diploma	39	0.72	0.76	
	Total	187	1.10	1.03	
I found good cooperation and acceptance from my colleagues from the other branches	**Permanent plain**	14	1.86	1.35	0.052
	Board	134	1.70	1.05	
	Diploma	39	1.26	1.02	
	Total	187	1.62	1.08	

❖ The relationship between the all participants' satisfaction scores and teaching centres:

There were few statistical significant differences among teaching hospitals; In Kerbala teaching center, the satisfaction with vision and acceptance of seniors of other specialties about the nature of the FMR's work had lowest mean score than scores of other centres, P<0.004, also commitment of teaching hospital to curriculum in karbala teaching center had lowest mean score than scores of other centres P<0.005 , as it is shown in table (3-8).

Table (3-8): over all participants' satisfaction according to teaching centers.

		N	Mean	SD	P value
I would recommend family medicine to a student seeking advice.	Kerbala	53	2.02	1.05	0.076
	Babylon	22	2.14	0.83	
	Najaf	21	2.57	0.68	
	Bahgdad	73	2.42	1.07	
	Others	18	2.00	1.08	
	Total	187	2.25	1.01	
If I were to start my career over again, I would choose to be an FP	Kerbala	53	2.17	1.20	0.114
	Babylon	22	2.41	0.91	
	Najaf	21	2.86	0.73	
	Bahgdad	73	2.62	1.30	
	Others	18	2.22	1.35	
	Total	187	2.45	1.20	
I was satisfied with my	Kerbala	53	1.11	1.03	0.129

FM residency program	Babylon	22	1.27	0.83	
	Najaf	21	1.33	1.06	
	Bahgdad	73	1.45	1.04	
	Others	18	1.83	1.38	
	Total	187	1.36	1.07	
Continuation table 3-8		N	Mean	SD	P value
My training program has met my expectations	Kerbala	53	1.40	1.25	0.623
	Babylon	22	1.23	1.02	
	Najaf	21	1.29	0.90	
	Bahgdad	73	1.56	1.12	
	Others	18	1.67	1.50	
	Total	187	1.45	1.16	
Senior doctors of other specialties had an acceptance, understanding and vision about the nature of the family doctor's work	Kerbala	53	0.77	0.85	0.004
	Babylon	22	1.64	0.79	
	Najaf	21	1.24	0.70	
	Bahgdad	73	1.18	0.93	
	Others	18	1.17	1.15	
	Total	187	1.12	0.92	
Senior doctors of other specialties were carefully follow up the students through the training program	Kerbala	53	1.15	0.93	0.987
	Babylon	22	1.18	0.80	
	Najaf	21	1.24	0.77	
	Bahgdad	73	1.18	0.93	
	Others	18	1.28	0.96	
	Total	187	1.19	0.89	
Teaching hospitals is committed to the curriculum	Kerbala	53	0.68	0.83	0.005
	Babylon	22	1.14	0.94	
	Najaf	21	1.33	1.02	
	Bahgdad	73	1.36	1.17	
	Others	18	1.00	0.77	
	Total	187	1.10	1.03	
I found good cooperation and acceptance from my colleagues from the other branches	Kerbala	53	1.40	1.08	0.267
	Babylon	22	2.00	1.02	
	Najaf	21	1.71	0.78	
	Bahgdad	73	1.64	1.13	
	Others	18	1.61	1.14	
	Total	187	1.62	1.08	

Understanding availability and characteristics of residency programs in family medicine is important and its measurement should become an integral part of health facility management strategies. Assessment of residents' satisfaction offers a way of optimizing health status and prevent possible family medicine shortage.

Majority (93%) of respondents in the current study were female; This is higher than the studies in Tarrant county in Texas in which half of participant were female(44), and study in Saudi Arabia in which half of residents were also female(15). There is an obvious tendency for female to specialize in family medicine in Iraq. This high proportion could provide positive impact since Iraqi woman in our society preferred to be evaluated by female doctor, and also in Iraq females client visit primary health center more than males; This may be due to their health concern, antenatal, natal, postnatal care or for their responsibility for caring their children, this goes with study conducted in Baghdad 2010 in which 83% females rate of clients(45) , and 70.6% of females were the clients during study done in kerbala 2017(46).

The mean age of participants in the present study were 32 belonging to the age group of 27 to 50 years.

The concept of family medicine is still not well understood. Not only by people but even from health care workers and physicians from other specialties, including some of those who involved in training of family medicine residents. This issue probably affects the training and attitudes with family medicine workers including residents. Based on the survey results, the level of respondents who choose family medicine by interest was low (29.9%). This might indicate that the respondents might not had prior knowledge and willing about family medicine. It may be related to lack of information about family

medicine. Anyhow, no figures on interest regarding other specialties in Iraq are available to compare with. As those might also had chosen their specialty for reasons other than their will. The availability or more income or any could be the reason to choose. Most of FMR (69.5%) choose it to balance their personal life and work because family medicine work in Iraq has no night shifts and the worksite could be close to their residency. However, when they had been asked about their willingness to choose family medicine as a career over again about (54.5%) agreed and same percent disagreed with that family medicine no longer appeal to them; This leads us to conclude that their awareness and knowledge might be increased after practicing the branch and giving correct perceptions to junior physicians seeking advice regarding joining family medicine training. Those juniors who are guided by FMR will have an obvious impression of the concept of FM and better identify career practice and they will be characterized by being more adapted with the wide range of general medical knowledge, seeking another opinion, possession of strong human values, as well as being more concerned about lifestyle issues that suited with a variety of practice (47).

Most likely factors in family medicine expressed by respondents were; there no night shafts, comprehensive branch, away from problems and less working hours; so these reason lead them to choose being family medicine doctor especially female doctors.

Unfortunately training program does not meet residents' expectation by (61.0%). Our results demonstrate dissatisfaction of respondents with training program, this goes with finding of a study in Botswana in South Africa(48), while the study in Tarrant county in Texas shows early family medicine career satisfaction(44). And this could be due to lack of adherence of teaching

hospitals to training curriculum or weakness in the trainers' role. Other possible factors for their dissatisfaction were lack of awareness and knowledge of seniors and residents of other branches about concept of family medicine, lack of understanding of the role of family doctors and the nature of training program in addition there could be some non-clarity in the administrative documents about the nature of the work of the family residents or training curriculum.

Residents highlighted some shortage in training to practice full-spectrum family medicine, the overall participants' satisfaction score (16%), about (54%) report inadequate hand-skills experience and about (52.4%) stated that the program was not emphasized training in performing procedures. This could be related to inadequate staff and trainers or limiting residents training to only outpatient, family medicine residency program should work toward providing broad comprehensive training to their residents and it will be a great mistake when the training of family residents is limited to outpatient context(44), However, other explanation could be lack of trainers' and/or FM residents' themselves to the interest in learning. These opinions need to be considered seriously by the supervisors, trainers and the persons who are responsible on putting or evaluating these training curricula whether in Arab Board, Iraqi Board or diplomas. Some points could be related to the curricula by itself, or to the application of these training curricula.

Further, participants expressed that the lack of supervision was associated with their dissatisfaction with the program. So, increasing the number of supervisor and activating their real role during the training might be essential as reported in a study in Saudi Arabia (49). The presence of FM supervisor in training centers could be of great benefit to adopt resident training, rotation in different specialty, organize their schedule in cooperation with other specialty, in order to make FM residents to be like other specialty in training centers under

direct supervision with their faculty, this leads to be more comfortable and supportive.

Other possible factors of dissatisfaction were lack of awareness and education in the community about concept of family medicine, the branch is still marginalized in Iraq, low income, low level of facilities in PHC centers, limited or no subspecialty, no support to family medicine doctors and filing defect of other specialty tables in ER or ward in hospital; as many Training centers wanted more efforts to be exerted by FM residents than their training protocols.

Doctors' satisfaction is a critical topic not only for physicians themselves but also for clients and health care administrators. It had been proposed that client satisfaction and physician satisfaction are associated. Anticipating highest level of career satisfaction by finding model is important because it may influence the whole rebuilding process(50). Factors that increase doctors' satisfaction reported by participants in this study are: doctor-patient relationship which was the highest option had been selected and this has a very positive impact on healthcare quality and it will lead to patient satisfaction, intellectual stimulation which is important for brain storming and skills development, prestige of medicine which reinforce self-confidence, interaction with colleges which strengthens the cohesion of family doctors and support the branch. This was noticed through high level of participants' satisfaction with their relationship with faculty members from family & community medicine and FMR colleagues and financial rewards which regarded a motivator to any worker in any sector. In order to induct more students to assume family medicine as a career. It is important to satisfy with practice. Induction and maintenance have major implications for the future family physician workforce(51).

A negative impact on doctors' job satisfaction is closely associated with high levels of stress at work. Factors that decrease FM satisfaction reported by residents in this study (in descending order in term of percentage) are: pressure of running practice, lack of personal time, non- clinical paper work or office work & dealing with trouble maker medical client, in addition some of them mentioned low salary. These are not unexpected for family doctors as most doctors in any specialty suffer or mention these reasons.

There were no statistical differences between Board and Diploma except few points in which the overall Board scores were higher than Diploma scores this may be caused by the condensation of training of Diploma in two years.

Regarding teaching centers, there were no statistical differences except of commitment of training centers with curriculum Kerbala had lowest score than other centers. This may be related to overall shortage in residents in hospitals, furthermore it is the only general hospital in governorates always there is load in number of patients. Therefore, the schedule of FM residents could be hard during their rotation in order to overcome the shortage in residents number in addition there is no specific guidelines for training protocol.

These few statistical differences mean that the problem is not specific to one teaching center or to one job description; it is a general problem and the curriculum should be reconsidering, clarify and customize the work and training of FMR should be done in training centers.

Regarding their interest in leaving Iraq, (29.9%) are interested in leaving. Anyhow as most of Iraqi people seek for more human rights and because of threats and terrorism in country.

Good finding…. their best description about how they feel about the future of their medical professional, (75%) of participants have bright vision and they believe that the future will be better. This gives delightful consequences for the branch and attracts the students to join it.

Limitation:

The questionnaire was self-administered so the rate of non-respondent may be high and may bias the result, also the answer may be incomplete. We didn't explore all aspect of residency training and we didn't survey all residents because of shortage of time.

I cannot generalize my study to the population (whole FM residents) because the sample is convenient. So I suggest further study using random sample.

Conclusions

Family medicine residents still in favorite of their specialty, but they have many drawbacks related to their residency training curricula and the application clinical training in the hospitals. Including lack of commitment of teaching hospitals to the curriculum; low awareness and acceptance of other specialty seniors or residents to the concept of family medicine; shortage in direct supervision at training centers; inadequate hand skills experience and the absence of family medicine specialist supervision in hospitals. These points could be the possible causes of dissatisfaction. As well as lower understanding of the community to the relatively new FM specialty, lack of incentives and motivations for workers at PHC centers and no limited opportunities for subspecialties for family physicians. These points are realistic and need to be taken seriously by training supervisors and higher committees concerned with family medicine in regards to training and by policy makers in regards to support and motivation if they are really willing to develop health system and providing a high quality of health care based on universal health coverage.

Recommendations:

1. We hope that the undergraduate students have full awareness with content and challenges associated with family practice by exposing to the family medicine during their education before graduation.
2. This study calls for further researches in the future to define and determine FM residents 'satisfaction with program and the need for recurrent surveys for evaluation of the program.
3. We wish further study about perception, attitude and knowledge of other specialty (seniors and residents) and community about the concept of family medicine.
4. We hope that the MOH defines an obvious career lines for residents with adequately organized program
5. We recommend doing education campaigns to inform community about what family medicine is, and its importance in primary care setting.
6. It is better for Department of Family Medicine to involve family medicine specialist supervisor in teaching hospitals to directly supervise their students and be responsible for their training in collaboration with other specialty doctors.

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Appendices

Questionnaire

Dear family resident doctors ... Peace be upon you ... We aim to carry out a scientific research on the subject of the impressions of family residents about the concept of their specialization and the detection of the factors that affect their training in the training centers in order to assess their conviction and satisfaction in their field of specialization for a better health out come in the future.

Note that "this form does not contain the name of the participant and the confidentiality of the answers will be saved, and will be used for research purposes only. So please help us put a correct mark in front of the paragraph that suits your answer with sincere thanks and appreciations.

- **Part one**

1. Age ☐
2. Gender: male ☐ female ☐
3. Marital status **:** single ☐ married ☐ divorced ☐ widow ☐
4. children number**:** ☐
5. living city
6. Graduation year
7. Teaching center (Department of Health)
8. Position / Job description**:**

- Permanent plain
- Board 1st ◯ 2nd ◯ 3rd ◯ 4th ◯
- Diploma 1st ◯ 2nd ◯

- **Part two**

9. why you choose family medicine (encircle answer/s) :-

a) I'm interested	yes	no
b) Less working hours	yes	no
c) Competition for specialty	yes	no
d) Convenient (near to my residence)	yes	no
e) I can make a balance between my family or personal life and my work.	yes	no
f) Others (mention):		

Put (√) in front of the correct answer:-

	Strongly dis agree	disagree	Neutral	Strongly agree	agree
Family Medicine career Satisfaction					
10.If I were to start my career over again, I would choose to be an FP.					
11 .I would recommend family medicine to a student seeking advice.					
12. Family medicine no longer has the appeal to me it used to have.					
Training and work place satisfaction					
13.my training program has met my expectations					
14. My work in this practice has not met my expectations					
15. I was satisfied with my FM residency program.					
16. I was trained to practice full-spectrum family medicine.					
17. My residency trained me well to care for complex patients.					
18.The time for residency is enough to get experience					
19.I ‘m involved in different activities like researches, teaching, meetings, training					
20. .My residency program emphasized training in performing procedures					
21. There was adequate hands-on experience					
22. I was not trained to be the principal physician for complex hospitalized patients					
23. My residency program					

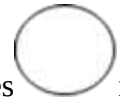
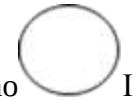
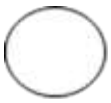
should have been more demanding.					
The nature of relationships and dealing during training					
24.I had good relationship with faculty members from family medicine & community medicine					
25. There was a supervisor in my training program in each step					
26. I had good relationships with seniors of other specialties in hospitals					
27. Senior doctors of other specialties had an acceptance, understanding and vision about the nature of the family doctor's work					
28. Senior doctors of other specialties were carefully follow up the students through the training program					
29. The relation with FM colleagues is good and supportive					
30.I found good cooperation and acceptance from my colleagues from the other branches					
31. Teaching hospitals is committed to the curriculum					

32. What is satisfying you more about family medical practice: (encircle the correct answer/s) :-

a) Doctor-patient relationship.	yes	no
b) Prestige of medicine.	yes	no
c) Intellectual stimulation.	yes	no
d) Interaction with colleagues.	yes	no
e) Financial rewards.	yes	no
f) Others (mention):		

33. What is less satisfying you about family medical practice: (encircle the correct answer/s,):-

a) Lack of personal time.	yes	no
b) Dealing with medical client.	yes	no
c) Pressure of running practice.	yes	no
d) Non- clinical paper work.	yes	no
e) Others (mention):		

34. Are you interested in leaving Iraq? Yes  no  I don't know now 

put (Y) inside of the correct answer

35. If yes in Q 34 , what are the causes: (encircle the correct answer/s,):-

a) The training program is not satisfactory	yes	no
b) The salary is not enough	yes	no
c) I want higher level of education	yes	no
d) I am in developing country and I want to be in developed one	yes	no
e) Outside there is more human rights and doctor rights	yes	no
f) threats and terrorism In my country	yes	no
g) other		

36. In general, which best describe how you feel about the future of your medical professional?

(Put (Y) in front of the correct answer):-

Very positive -----

Positive -----

Negative-----

Very negative-----

- # Part three

37. What do you like most about family medicine?

38. What do you dislike most about family medicine?

Any addition or suggestion…….

Thanks

بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

أعزائي أطباء وطبيبات الأسره المقيمين الأقدمين...السلام عليكم...

نهدف لأجراء بحث علمي تحت عنوان :

(انطباعات أطباء الأسره المقيمين الأقدمين حول مفهوم أختصاصهم والكشف عن العوامل التي تؤثر على تدريبهم في المراكز التدريبيه)

وذلك من أجل تقييم قناعتهم ورضاهم في مجال أختصاصهم (طب الأسره) والعمل على النهوض بالبرنامج التدريبي من أجل مستقبل صحي أفضل.

علما" أن هذه الأستماره لا تحتوي على اسم المشارك وسرية الاجابات ستحفظ، وسوف تستخدم لغرض البحث فقط.

لذا يرجى مساعدتنا بوضع علامة صح أمام الفقره التي تناسب إجابتك مع خالص الشكر والتقدير.

❖ **الجزء الاول :- المعلومات الوصفية للعينة**

1. العمر ☐
2. الجنس : ذكر ☐ أنثى ☐
3. الحاله الزوجيه:أعزب ☐ متزوج ☐ مطلق ☐ أرمل ☐
4. عدد الأطفال ☐
5. السكن (المحافظه)
6. سنة التخرج (شهادة البكلوريوس)
7. المركز التعليمي للدراسه (دائرة الصحه) :
8. التوصيف الوظيفي :
   - مقيم أقدم plain
   - طالب بورد 1^{st} 2^{nd} 3^{rd} 4^{th}
   - طالب دبلوم 2^{nd} 1st

❖ **الجزء الثاني:**——————

9. لماذا أخترت فرع طب الأسره؟

أحب هذا الأختصاص ومن ضمن أهتمامتي	نعم	كلا
لأنه يتميز بساعات عمل أقل	نعم	كلا
ماكان متاحا" لي أثناء المقابله	نعم	كلا
لأن هذا الأختصاص يتم توزعي للأقامه القدمى نفس محافظة سكني	نعم	كلا
هذا الأختصاص يمكنني أن أوازن بين حياتي الشخصيه أو العائليه وحياتي المهنيه	نعم	كلا
أسباب أخرى, تذكرها		

ضع علامة صح (√)أمام الخيار الذي يناسب أجابتك

	موافق بشده	موافق	محايد	لا أوافق	لا أوافق بشده
القناعه بالحياة المهنيه لفرع طب الأسره					
10.لو عاد بي الزمن مره أخرى لأخترت طب الأسره مجددا"					
11.سأنصح الأطباء الذين يودون التقديم على الفروع أو الأختصاصات الطبيه بالتقديم لطب الأسره					
12.لم يعد طب الأسره ينال أعجابي					
القناعه بالجدول ,المنهاج التدريبي ومكان العمل					
13.كان الجدول التدريبي للمنهاج الدراسي كما توقعت					
14.مزاولة المهنه لم يكن كما هو متوقع					
15.أنا راضي أو مقتنع بالمنهاج التدريبي					
16.تم تدريبي على ممارسة المهنه بشكل واسع وشامل					
17.الأقامه القدمى دربتني بشكل جيد لرعاية المرضى ذوي عدة أمراض بنفس الوقت					
18.الفتره الزمنيه للأقامه القدمى كافى للممارسه المهنيه					
19.أحرص على المشاركه في أنشطة مختلفه مثل البحوث العلميه ,الأجتماعات والموتمرات					
20. لقد أكد برنامجي التدريبي على تنفيذي لبعض العمليات والتداخلات السريريه					
21.كانت هناك خدمه عمليه سريريه كافيه					
22.لم أكن مدربا" لأكون الطبيب الرئيسي لمرضى المستشفى متعددي الأمراض					
23. .يجب أن يكون برنامج الإقامة أكثر عطاءا"					

	موافق بشده	موافق	محايد	لا أوافق	لا أوافق بشده
طبيعة العلاقه والتعامل خلال التدريب					
24.كانت لي علاقه جيده مع أعضاء هئية التدريس من أساتذة طب الأسره وطب المجتمع					
25.كان هناك مشرف في برنامجي التدريبي في كل خطوه					
26.كانت لي علاقه جيده مع أطباء الأختصاص للفروع الأخرى في المستشفيات					
27.أطباء الأختصاص من الفروع الأخرى كان لديهم تقبل وتفهم ورؤيا عن طبيعة عمل طبيب الأسره					
28.كان الأطباء من الأختصاصات الأخرى حريصين على متابعة الطلبه خلال فترة التدريب السريريه					
29.كانت علاقتي مع زملائي المقيمين الأقدمين أطباء الأسره جيده وداعمه					
30.وجدت تعاون وتقبل جيد من زملائي المقيمين الأقدمين من الفروع الأخرى					
31.المستشفيات والمراكز التدريبيه ألتزمت بالمنهاج التدريبي					

32. مالذي يزيد من قناعتك ورضاك لمهنة الطب؟

العلاقة بين الطبيب والمريض	نعم	كلا
برستيج الطب.	نعم	كلا
التحفيز الفكري	نعم	كلا
التفاعل مع الزملاء	نعم	كلا
المكافآت المالية	نعم	كلا
أخرى.. تذكر		

33.مالذي يقلل من قناعتك بالمهنه الطبيه؟

الأفتقار للوقت الشخصي	نعم	كلا
التعامل مع المرضى	نعم	كلا
ضغوطات العمل	نعم	كلا
العمل غير السريري	نعم	كلا
اخرى...تذكر		

34 .هل تفكر بمغادرة العراق؟ نعم ☐ لا ☐

لا أعلم حاليا" ☐

35 .إذا كان الجواب نعم في Q 34، ما هي الأسباب :

الجدول التدريبي غير مقنع	نعم	كلا
الراتب غير كافي	نعم	كلا
أرغب بمستوى ثقافي تعليمي أرقى	نعم	كلا
أنا في بلد من البلدان النامية وأريد أن أكون في بلد متطور	نعم	كلا
في البلدان المتطوره هناك حقوق للطبيب والانسان	نعم	كلا
الأوضاع غير المستقره في العراق	نعم	كلا
أخرى... تذكر		

36 .بشكل عام، صف أفضل شعور لك حول مستقبلك الطبي المهني؟ ضع علامة صح (√)أمام الخيار الذي يناسب أجابتك:

إيجابي جدا ◯ إيجابي ◯ سلبي ◯ سلبي جدا ◯

❖ **الجزء الثالث**

37- ما هو اكثر شيء يعجبك بتخصص طب الاسرة؟

38. ما هو اكثر شيء لا يعجبك بتخصص طب الاسرة ؟

هل لديك أضافه أو مقترحات.....

شكرا"جزيلا"

الخلاصة

خلفية البحث:

أن تخصص طب الأسرة يتطلب مجموعة واسعة من الخبرة والمعرفة و إكتساب المهارات. فيجب أن يتعامل المقيم الأقدم لطب الأسرة مع المشاكل الصحية الشائعة في إطار الرعاية الطبية المستمرة للمرضى.

يختلف تدريب المقيمين باختلاف مراكز التدريب. قد يكون هذا بسبب التباين في عدد المرضى، مشاكلهم الصحية ، العمر، الجنس والمستوى الأجتماعي والثقافي ، وعوامل أخرى. ومن الضروري تقييم تدريب المقيمين بأستمرار والكشف عن العوامل المؤثره على تدريبهم والكشف عن أنطباعاتهم حول مفهوم أختصاصهم.

الهدف من الدراسة

الهدف من هذه الدراسة هو تقييم العوامل التي تؤثر على التدريب السريري لمقيمن طب الأسرة في المستشفيات التعليمية ومراكز طب الأسرة وتقييم نسبة رضاهم عن البرنامج التدريبي والكشف عن أنطباعاتهم تجاه تخصص طب الأسرة.

طرق البحث

أجريت دراسة مقطعية في المراكز التعليمية في العراق من الأول من شباط حتى الثلاثين من تموز 2018. تم توزيع 275 ورقة استبيان على مقمين طب الأسرة في مختلف المراكز التعليمية ،و تم جمع البيانات من خلال الأستبيان الذاتي والذي كان معد باللغة العربية.

النتائج

معدل درجة عدم الرضا بشكل عام (63.6 ٪) عن البرنامج التدريبي. وكان السبب الرئيسي هو عدم التزام المستشفيات التعليمية بالمناهج التدريبي ، قلة وعي وقبول ، وفهم أطباء الأختصاصات الأخرى حول طبيعة عمل طبيب الأسرة ، وأعداد المشرفين غير الكافي ، وضعف في تنظيم البرنامج. ومع ذلك ، كان المقمين راضين عن علاقتهم مع زملائهم و أعضاء هيئة التدريس من طب الأسرة والمجتمع.

الاستنتاجات

على الرغم من عدم الرضا العام بسبب العقبات التي تواجه برنامج التدريب ، وجدنا أن هذه الدراسة التقييميه بينت لنا إلى أي مدى تحققت أهداف هذا البرنامج . كما و يمكن للمقيمين أعطاء اقتراحات من أجل وضع حلول لتحسين برنامجهم وبالتالي توفير خدمات الرعاية الأولية بشكل أفضل .

نأمل أن تقوم وزارة الصحة بتحديد خطوط مهنية واضحة لمقيمين طب الأسرة و تنظيم البرنامج بشكل أنسب في المستقبل.