‘These reforms killed me’: doctors’ perceptions of family medicine during the transition from communism to capitalism

Slawomir Czachowski\textsuperscript{a,*} and Teresa Pawlikowska\textsuperscript{b}

\textsuperscript{a}Family Doctor Department, Medical College in Bydgoszcz, Nicolaus Copernicus University, Torun, Poland and \textsuperscript{b}The Institute of Clinical Education, Warwick Medical School, The University of Warwick, Coventry CV4 7AL, UK.

\textsuperscript{*}Correspondence to Slawomir Czachowski, 87-100 Torun, Grabowa 10, Poland; E-mail: s.czachowski@to.home.pl

Received 15 July 2010; Revised 31 December 2010; Accepted 8 January 2011.

Background. The establishment of family medicine (FM) in Poland following political reform.

Objectives. To describe family doctors’ (FD) experiences during the introduction of FM.

Methods. A qualitative study of 25 FDs in Poland, using thematic analysis of semi-structured interviews. Open-structured narrative-based interviews with five FDs were then used to deepen understanding of the major emergent themes. Fifteen of 25 had a different initial specialization to FM; 10 of 25 overseas work experience.

Results. Many doctors were driven by personal circumstances to engage with this new discipline, which provided a better fit with their life circumstances and a chance to escape from hierarchical structures characterizing the old regime. Personal experience of role models helped embrace FM, whereas adherence to ingrained biomedical approaches led to difficulty with exposure to common problems and could facilitate burnout. Shifting relationships in the reformed system caused tensions between primary and secondary care. While relationships with patients and specialists were being renegotiated, the concept of an independent FD practice surfaced. We observed that the most serious problems that the doctors encountered were circumstances related to the former health care system, in contrast to any lack of professional skills.

Conclusions. This is a rare qualitative study exploring Polish doctors’ perspectives of the health care reform after the collapse of communism in Central and Eastern Europe. This analysis of newly qualified FDs has provided an insight into the authentic experiences, and motivation of grass roots FM pioneers in Poland.

Keywords. Family medicine, health care reform, Poland.

Introduction

Since the demise of communism in Central and Eastern Europe (CEE), the health care system in Poland has been changing.\textsuperscript{1,2} Reform has concentrated on the delivery, management and financing of the health care sector,\textsuperscript{3,4} strengthening primary health care. The former centralized state-owned model has been transformed into a health insurance scheme, the newly established National Health Fund (NHF), taking responsibility for financing and contracting doctors’ services.\textsuperscript{5} This process was initially supported by European projects [Poland and Hungary: Action for the Restructuring of the Economy (PHARE)] and World Bank.

With the implementation of family medicine (FM) in Poland in 1994, and after the first medical practices were opened in 1995, doctors were able to establish their independent practices and sign contracts with the NHF, although this process was slow and patchy. Access to primary care was free for patients and they could choose their family doctor (FD).

Few studies deal with problems within the health care system after the collapse of communism in CEE and most of those that do centre around patients’ views.\textsuperscript{6–9} The aim of this study was to explore personal experiences of doctors during the introduction of FM in Poland.

Methods

Setting

This study took place in the Kuyavian-Pomeranian Voivodeship and was conducted in 2003–04. The first FD practice of this province (1 of 16 in Poland, in the central north) was established in 1997, but in the intervening period, numbers grew slowly and with...
difficulty. This was also accompanied by serious problems concerning lack of finances or logistics.

Sampling
These doctors were recruited from the complete list of 30 members of the Regional Family Doctor Centre in Torun. All 30 were invited to participate by telephone; 25 gave informed consent. The sample for the initial exploration with individual semi-structured interviews comprised of all doctors who were in the first cohort in the region to take their specialization examinations in FM (20 in total). For the second part of the study, detail relevant to the emergent themes obtained was explored in a more open interview with those who were the first to establish their own practices (a group of five FDs). The interviews took place in these doctors’ surgeries, except for four interviews that were conducted in one of the authors’ practice. (SC)

Research design
Twenty certified FDs participated in semi-structured interviews (topic guide in Appendix 1), carried out by one of the authors (SC) until saturation of major themes.10,11 The researcher summarized the interviews for respondent validation. Interviews were recorded and transcribed verbatim and the transcripts were analysed thematically,12 independently by the authors (SC and TP), who then discussed and reviewed the analysis, re-read the transcripts and refined major emergent themes.

The researcher (SC) explored these themes further by open-structured narrative interviews with five GPs. Each interview started with an introductory question about the doctors’ personal experiences in establishing their own practices. Each recording lasted about 2 hours and took place at the doctors’ workplace. Interviews were again recorded, transcribed and analysed thematically, independently by the two researchers, and selected quotations were then translated into English (SC and TP).13 Typical examples are presented.

Results
Characteristics of participating FDs are illustrated in Tables 1 and 2. Twenty-three of 25 doctors mentioned that they originally had no medical background in terms of their family or friends before going to medical school, and most mentioned that they had excelled at school, although some had taken more than one attempt to pass the highly competitive entry examination into the medical academy. Fifteen of 25 had another medical specialization in internal medicine, pediatrics or surgery. In terms of role models, 10 of 25 doctors derived them from their work experience in the USA, Canada, Italy and Germany.

The findings of semi-structured interviews are grouped under the following five themes:

Circumstances in which doctors decide to embark on a career in FM
This deals with various conditions under which respondents decided to become a FD. For some, FM as a new specialization was the opportunity to further their professional development, particularly those with a holistic approach:

in my youth I dreamed about becoming an ‘all-knowing doctor’ . . . although I started my medical career as a well-paid military physician, I gave it up to become a FD. (male 1, 41)
during my medical studies I often visited my sister in the USA, where I met American family physicians who had their own practices . . . in Poland I worked as a prominent director of a sanitary station. When the FM project was introduced, I made a success of my own family practice. (male 2, 41)

For others, it was driven by life-events: FM provided new opportunities, which provided a better fit. These examples show the role of coincidental events in becoming a FD:

when my husband died and I found out about well-paid jobs offered by Regional Family Doctor’s Educational Centre, I passed the exam to work as a FD. (female, 44, two children)
I worked as a full-time assistant at the hospital that soon had to be shut down . . . the only way-out for me was to specialize in FM. (female, 37, two children)

| TABLE 1 Characteristics of participating doctors in semi-structured interviews |
|---------------------------------|------------------|
| Sex                             | Semi-structured interviews (n = 20) |
| Sex                             | Semi-structured interviews (n = 20) |
| Male                            | 9                |
| Female                          | 11               |
| Doctors skilled in other disciplines (internal diseases and paediatrics) | 12               |
| Doctors without previous skills | 8                |
| Doctors with previous overseas work experience | 7                |
| Doctors without previous overseas work experience | 13               |
| Age mean years ± (SD)          | 41.8 (5.75)      |
| Range                           | 21               |
| Minimum–maximum                 | 34–55            |
| Workplace                       |                   |
| City >100 000 inh.              | 10               |
| Small town 20–50 000 inh.      | 7                |
| Village                         | 3                |
Gaining or losing professional identity

Personal development and professionalism were important themes. There were examples of doctors who on passing the professional exam identified deeply with their new role. For them, FM offered rewarding career opportunities and self-fulfilment:

I used to work as an anaesthetist before obtaining a FD diploma and opening my own practice . . . and after, I gained high prestige and earned much respect among patients. (female, 42)

I was always the best pupil . . . I passed my internal medicine exam with flying colours. Although I was to become an endocrinologist, I changed my specialization for FM and opened my own practice to become an independent contractor. I am very happy about that decision. (female, 49)

There were also a few examples of how doctors’ enthusiasm waned and led to the ending of their activity in FM.

my FD career was never accepted by my father, who was an eminent country internist, so after a few years of working as a self-employed FD, I broke my contract, specialized in rheumatology and I became a senior registrar in the academic hospital. (male, 39)

I planned to be a researcher. I began to work at a public medical centre in a small town, which I later bought to set up my own practice. Thanks to the political reforms I was able to buy this centre. The list of my patients gradually enlarged and I had to employ more doctors. Finally, I became a medical manager and decided not to treat the sick. (male, 50)

Key elements during the socialization process

Although a minority described medical role models in their early life, this experience was pivotal in contributing to the socialization process of those FDs.

my aunt was a nurse and I remembered patients coming every day to ask her for injections. At the beginning of my medical studies I wanted to ‘treat people whenever they needed help’. Working in my own practice is like building an extended family and fulfilling my dream to follow in my aunt’s footsteps. (female, 44)

I often visited my sister in a hospital laboratory, where I could use microscopes to observe microbiological cultures. In secondary school, my classmate (later my wife) persuaded me to study medicine. I am very satisfied with working together with my wife, also a FD. (male, 37)

The importance of gender

Socially constructed (and occasionally dismantled) differences between men and women turned out to be crucial in affecting life decisions, for female FDs in particular. Two different outcomes of becoming an independent female FD are illustrated in the following quotes:

for 13 years I had been working in different hospitals as an internal medicine specialist. As FM was launched, I passed my FD exam and became an independent FD. My husband, an economist, helped me to bring up our children and shared the household duties. (female, 46, four children)

my husband worked as a pathologist at the hospital for little money . . . when FM was introduced, I decided to sign an independent contract. I became a self-reliant manager and a financially independent woman. This led to the breakdown of our marriage. (female, 34, two children)

Burnout in FM

Even though FM is a new discipline, burnout was discovered:

many patients visited me with trivial ailments, complaining about everything. I was not able to stand ‘giving advice for the same banal question’. I felt thorough exhaustion and depletion. Finally, I decided to break the contract and emigrate. (male, 36)

I worked very hard, often visited pathological families, giving them medicines for free . . . After several years, I had felt tiredness and complete exhaustion. I said: ‘Life has been passing by very quickly at a low price’. I decided to reduce the
number of patients and adopt two sick children. (female, 37)

These doctors felt stressed by the ‘monotony of unrelieved problems’ rooted in poor socio-economic conditions.

**Shifting relationships**

Thematic analysis of open-structured interviews enabled a deeper exploration and understanding of the major themes discussed above. Box 1 gives examples of typical quotes.

Central to all narratives were relationships between FDs and other groups of people in the reformed health care system, including health administrators, patients and specialists. There was conflict over contracts with the emergence of FDs’ battle with hospital specialists for patients. Clashes between FDs and specialists over medical qualifications were particularly common. Lack of experience made the doctors get their ideas for family practice mainly from observation, drawing on their experience gained from travelling and working abroad (see Box 1).

**Discussion**

This is a rare qualitative study exploring Polish doctors’ experiences of the health care reform after the collapse of communism in CEE, which led to the introduction of FDs. Many doctors were driven by personal circumstances and a chance to engage with a new discipline, which provided a better fit with their aspirations or life circumstances and a chance to escape from established hierarchical structures, which had characterized the old regime (see Table 3). Personal experience of role models, in the few cases where it existed, supported a positive move to embrace and develop FM, whereas adherence to ingrained biomedical approaches led to difficulty with ongoing care of the common problems frequently encountered in primary care and could facilitate burnout. Shifting relationships with others in the reformed system, and competition for patients and payment led to tensions in practice. We observed that the most serious problems the doctors said that they encountered while partaking in the process of implementing FM were circumstances related to the former health care administration system in contrast to any lack of professional skills.

**The FDs**

Polish FDs did not have any previous experience with the new implemented FM model. Most doctors described being exemplary students, not always in the sciences, and most articulated self-belief in attaining their aspirations, sometimes resitting the fiercely competitive entry exam to the medical academy until they were admitted. Inevitably, offers of hospital posts in general medicine with tied free accommodation (especially if they had dependants) were attractive in the hierarchical system. However, once reform offered the opportunity to engage with a new, rather more

---

**Box 1 Major themes emerging from narrative analysis with representative quotes:**

<table>
<thead>
<tr>
<th>Relations between FDs and health administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>“next was my contract . . . and these reforms killed me. I felt as if I was a slave of a terribly organized health care system. I paid a horrible price for what I am doing and I had enough of it.” (male, 46, village)</td>
</tr>
<tr>
<td>“as the contracts appeared I got into a serious conflict with local councillors. They wanted me to pay a high rent for an old, dilapidated building. They were nasty people and many problems I dealt with were for–no–because of their rule”. (female, 48, village)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relations between FDs, patients and other specialists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“patients thought that being the house doctor meant the doctor’s visits in people’s houses. Dozens of patients called me every day to order their home visit . . . I had 80 patients a day on average and I felt frustrated”. (male, 46, village)</td>
</tr>
<tr>
<td>“… specialists looked askance at us, they thought that we took their patients. There was a certain period of time when specialists didn’t want to order laboratory tests . . . they used to tell patients ‘go to your FD, he ought to order and pay for medical examinations.’ What should I say, I had to pay but I shouldn’t have”. (male, 52, small town)</td>
</tr>
<tr>
<td>“specialists perceived FM as a discipline which destroyed what they had been creating for years . . . now they come to the conclusion that our job is well-done”. (female, 36, big city)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The concept of a FD practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I used to work as a paramedic in Canada. I had never got to the level of a doctor. That’s why I don’t want to go back to Canada, even though this place here is a pigsty. I said ‘no’, I want to be a doctor. Now, here is my work, my house at the lake. This is my small Canada”. (male, 46, village)</td>
</tr>
<tr>
<td>“I went to Vienna in Austria; they suggested that I should stay there . . . but I didn’t . . . I think it was a good move to start training in FM and to set up my own practice. I am 56, a self-supporting practice forces me to learn computer science, management, and to be expert in administrative law”. (male, 56, small town)</td>
</tr>
</tbody>
</table>
entrepreneurial model of health care, many seized the chance both to reject the old order and to function independently in primary care. Many of those who became FDs did not have medical role models in their immediate environment but personal contacts, which then provided role models from abroad, as seen elsewhere.18 Family circumstances were a powerful influence on decision making. Furthermore, these doctors also described their private primary care practice as a family business and a chance for betterment for themselves and their families. Salaries, which had been relatively low,18 rose under the new arrangements of contracts with sickness funds but also under the increased capacity for out of pocket payments going to this group of doctors (as opposed to hospital specialists).

Despite institutional support from European projects, similar phenomena as in other FDs from western Europe were observed in Polish FDs. Specifically, stress19,20 or burnout21 syndrome, which had been noticed in many other countries, and gender-related problems affected these Polish FDs. Many interviewees pointed to their personal problems in family relations as crucial factors in their decision to set up their own practice. Meeting psychological, social and professional needs by FDs was not institutionally endorsed. Local FDs organizations were not so numerous at that time as to be able to support newly emerging medical practices.

Many of the problems, such as professional identity, gender, burnout syndrome and concept of being a FD, are similar to those experienced by their colleagues from other Western European countries. However, other issues are culture specific and are thus related to the history of the previous health care system, established by communists14 namely relations with health care administrators, specialists and patients—these are important influences on developing an understanding of Polish FDs’ personal experiences.22

### Problems connected with health policy

The introduction of FM in CEE presented some FDs with opportunities for a new professional career. For many, especially for early adopters, there was a fierce identification with the new role of FD. Yet, while, on the other hand, becoming a FD meant getting a unique chance to build up an independent position in the emerging medical market, which was not only personally rewarding but also resulted in higher financial position; on the other, it was seen as a transition: either a springboard to managerial careers or the road to decline in professional activity. However, like in other CEE countries, there appeared conflicts with health system administrators, protected strongly by the previous system. Similar changes in health policy were also observed in Estonia, Hungary, Bulgaria and Slovenia. Of main concern were privatization, bankrupting hospitals, fighting for patients and more and more profitable contracts with new insurers. They turned out to be big obstacles for emerging new FD practices. A great deal of these issues depended on the historically established health care system, known in Poland as ‘Bismarck model’.16 In this context, it is also worth highlighting that the interviewees did not point to difficulties in adapting to the new system in terms of lack of medical competence or skills.

The ongoing discussion concerning the new definition of a FD in Europe was mirrored in the narratives of the FDs, who had been gathering their own experiences and searching for their own model while traveling across the world.20 The pursuit of a new professional FD identity that was absent under communism in CEE was tied in with fear from losing the

### Table 3: A comparison of the main differences in primary health care in the previous (communist) and reformed (capitalistic) model in Poland

<table>
<thead>
<tr>
<th>Previous model (communist)</th>
<th>Reformed model (capitalistic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State-owned health care system</td>
<td>Universal health insurance scheme</td>
</tr>
<tr>
<td>Focus on specialists and hospital care system</td>
<td>Growing role of FDs in health care system</td>
</tr>
<tr>
<td>Centrally managed tax-based primary health care</td>
<td>Predominantly regional contract-based primary care (mixed payment: capitation and fee for service)</td>
</tr>
<tr>
<td>Hierarchical structure of primary health care in state-owned polyclinics</td>
<td>FD as an independent financial contractor in own FD practices</td>
</tr>
<tr>
<td>Paternalistic stance towards patients in polyclinics</td>
<td>Patient-centered model applied by FDs</td>
</tr>
<tr>
<td>No competition among primary health care professionals</td>
<td>Competition for patients among FDs and specialists</td>
</tr>
<tr>
<td>Lack of/poorly developed FD institutions</td>
<td>Introduction of FD institutions: vocational training, final qualifying exam, professional associations, Family Practice Departments at universities</td>
</tr>
</tbody>
</table>

Source: references numbers: 1,4,7,14–17.
job, on the one hand, and risk of failure in the implementation of a new FD model, on the other.

The implementation of a new discipline of FM in Poland proceeded successfully, despite lack of examples from the former system. Today, 16 years after the implementation of FM, there are 10,332 FDs in Poland. They are facing other challenges and have other obligations to meet such as, for example, improving the quality of medical services. The practical problems that had been piling up in the early years of the reform for some doctors did not turn out to be insurmountable and FM is now an established part of the health care system in Poland.

Strengths and limitations

The data we obtained in this study are noteworthy; in that, they present the doctor’s perspective reform process and we were able to obtain very personal testimonies from these newly accredited FDs. We have captured the data from most of the FDs in this particular area of Poland, although we have no further data on the relatively few non-participants; we have no reason to believe that they differ in terms of basic demographics from those who agreed to participate. This study is from an area of Poland where progress towards FM has been slow but typical, relative to other voivodeships in Poland (see Table 4). Where possible, we have compared our data to quantitative studies and reviews of the reform process in CEE and found common relationships have to be renegotiated in a landscape of health care reform, a topic high on the global agenda.

Conclusions

The analysis of these doctors’ experiences of reform provides a perspective on the forces that drive doctors to enter FM as a new discipline and explores the personal and professional circumstances where relationships have to be renegotiated in a landscape of health care reform, a topic high on the global agenda.

Acknowledgements

We would like to thank all FDs who took part in our interviews. Research perspectives in the future: This research should be repeated at a further time point after the implementation of FM in Poland in order to assess and compare progress.

Declaration

Funding: none.

Ethical approval: permission of the local ethical committee of the Kuyavian-Pomeranian Doctors Chamber in Torun.

Conflicts of interest: none (SC). TP was involved in the initial introduction of FM in Poland in the EU-PHARE project. She did not have anything to do with ongoing development in this region of Poland and did not directly or indirectly teach or have any contact with the doctors involved in this study.

References

4 SABBAT J. International assistance and health care reform in Poland: barriers to project development and implementation. Health Policy 1997; 41: 207–27.
7 Chlabicz S, Marcinowicz L. Public or non-public family medicine patients’ perspective of the quality of primary care in Bialystok, Poland. Eur J Gen Pract 2005; 11: 5–10.

Appendix 1

Topic guide for semi-structured interviews

1. Personal situation including: age, gender, birthplace, parents’ professions, social background and family traditions
2. Educational experience: school education, attainment, interests and decision to study medicine
3. Medical study: courses, exam results and main interests
4. Postgraduate probation period: first experiences in health system
5. Choice of FM
6. Establishing a FD practice
7. Family life: partner, children, parents and friends
8. Other interests: hobby and burnout