

## THE PATIENTS OF FAMILY MEDICINE CABINETS

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### Abstract

*A Report of the Presidential Commission for the analysis and the development of public health policies in Romania* has been drawn up in 2008. The *Report* shows that the medical system is built around central administration, medical staff, and patients are deprived of the effective power to influence it, despite the fact that they provide its funds. The report *recommends* that the system should place the patient at the centre. Credible data should be provided, as well as accessible information on the health services in the community, activities to improve the health status of inhabitants, and significant changes in the behaviour of patients. If establishing public health priorities and plans regarding public health are drawn up with the participation of patients, it is pertinent therefore to confer with them through surveys and analyze shared values. The participation of patients is not a universal panacea, but it can be a moral debt, when the community can benefit from such participation. Some of them are *expert patients* whereas others consider the disease a divine punishment... Based on the field research, we can identify the attitudes, values, and beliefs regarding habits and behaviours. Here we can find out the extent to which the consultation of patients is a necessary (and sufficient?) condition to make the appropriate decisions for improving the situation in the field of health care. Health sociologists can identify types of doctor - patient relationships, doctor's and patient's behaviour, logics and practices, expectations towards the doctor, expectations towards the patient. In this article, the author presents the results of a research on patients' satisfaction, based on the questioning of 496 patients from 180 cabinets of family doctors in a big city.

**Keywords:** health sociology, public health, medical services, family doctor, patient

### Résumé

Un Rapport de la Commission Présidentielle pour l'Analyse et le Développement de Politiques de Santé Publique en Roumanie a été élaboré en 2008. Ce Rapport montrait que le système médical est construit autour de l'administration centrale, du personnel médical et les patients sont effectivement impuissants à influencer d'aucune façon le système, les décisions, en dépit du fait qu'ils donnent de l'argent. Le rapport recommande au système de mettre le patient au centre, de fournir de données fiables, d'informations accessibles concernant les services de santé dans les communautés, en travaillant pour l'amélioration de la santé des habitants, pour de changements significatifs en ce qui concerne la participation des patients. Si les plans sont en priorité, ainsi que les activités liées à la santé publique, ceux-ci doivent être élaborés avec la participation des patients, au moins en les consultant par enquêtes. La participation des patients n'est pas la panacée, mais elle peut être même un devoir moral, dont les collectivités peuvent bénéficier. Certains patients sont des patients experts, mais beaucoup d'autres croient que la maladie est une ... punition

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divine et cherchent les remèdes aux mages ... Basé sur de recherches de terrain, l'auteur a identifié des attitudes, valeurs et croyances, des habitudes et comportements des habitants concernant la santé et la maladie. De cette manière on peut identifier si les avis des patients sont nécessaires (et suffisantes?) pour les décisions appropriées dans le domaine de la santé. Les sociologues de la santé peuvent identifier de types de relation médecin de santé - patients, les comportements de médecins et de patients, les déterminants sociaux de la santé, des logiques et pratiques, des attentes et aspirations. Dans cet article, l'auteur présente les résultats d'une recherche sur la satisfaction des patients, a partir de 496 entretiens avec des patients de 180 médecins de famille d'une grande ville.

**Mots-clés :** Sociologie de la santé, santé publique, soins de santé, médecin de famille, patient

### **Rezumat**

Un raport al Comisiei Prezidențiale pentru analiza și dezvoltarea politicilor de sănătate publică din România a fost elaborat în 2008. Raportul arăta că sistemul medical este construit în jurul administrației centrale, a personalului medical, iar pacienții sunt lipsiți de puterea efectivă a influența și ei în vreun fel sistemul, deciziile, în ciuda faptului că ei dau banii necesari. Raportul recomandă ca sistemul să pună pacientul în centru, să fie furnizate date credibile, informații accesibile privind serviciile de sănătate din cadrul comunităților, activități de îmbunătățire a stării de sănătate a locuitorilor, schimbări semnificative în privința participării pacienților. Dacă se fac planuri privind sănătatea publică, priorități și activități referitoare la sănătatea oamenilor, ele ar trebui elaborate și cu participarea pacienților, măcar consultându-i prin sondaje. Participarea pacienților nu este panaceu universal, dar poate fi măcar o datorie morală, de pe urma căreia comunitățile pot beneficia. Unii dintre pacienți sunt pacienți experți, dar mulți alții consideră boala pedeapsă divină și caută leacuri la vraci... Bazându-ne pe cercetări de teren, am identificat atitudini, valori și credințe, obiceiuri și comportamente privind sănătatea și boala ale locuitorilor ieșeni. Doar astfel putem afla dacă este consultarea pacienților o condiție necesară (și suficientă?) luării deciziilor adecvate pentru îmbunătățirea situației în domeniul asistenței medicale. Sociologii sănătății pot identifica tipuri de relații medic - pacient, comportamente ale medicului și pacientului, determinanți sociali ai sănătății, logici și practici, așteptări și aspirații. În acest articol autorul prezintă rezultatele unei cercetări privind satisfacția pacienților, plecând de la chestionarea a 496 pacienți ai 180 cabinete ale medicilor de familie dintr-un oraș mare.

**Cuvinte-cheie.** Sociologia sănătății, sănătate publică, servicii medicale, medic de familie, pacient

## **1. Sociological Research in the Field of Health**

The assessment of the inhabitants' health and its determinants transcends the biological dimension, medical diagnosis, administrative or media considerations. Health and disease vary according to the context of society, community, family and these factors are socio-culturally determined (Bourdieu, 1979). Their assessment also means the research of development gaps, differences in income, poverty, status and development of communities. The patterns of health and

disease vary according to people's personal situation, social-economic community membership, redistribution of commonwealth, and (in) equality of access to health care. If nowadays in the *traditional* villages disease is less regarded as a *divine punishment*, since the financial crisis, the economic recession and the *requirement of the rationalisation of collective resources*, it appears more closely related to individual responsibility, although there remain institutions responsible at societal level... There are no "major investigations" or "microresearch" field to find out how people perceive the institutions responsible for the health of the population, if they recognize signs of the disease on time, search for information in order to understand it and the cost of treatment.

A few years ago (in 2008), a *Report of the Presidential Commission for the Analysis and Development of Public Health Policy in Romania* has been drawn up, entitled *A Health System Centred on Citizens' Needs*. Since we joined the European Union, Romanians' health and sanitary services should be compared with those of member states. In this way, we could find out the number of people who die annually from disease, the rate of hospitalization in the EU and in Romania, the rate of medical staff per 1,000 inhabitants, our position in relation to the EU average<sup>1</sup>, how easy accessible are treatments and medication to the deprived categories etc. From the point of view of the performance of the Romanian health system in an international context, Romania was ranked at 99th place five years ago, after Albania (55th), Slovakia (62nd), Hungary (66th), and Estonia (77th)<sup>2</sup>. Specialists' analyses show that the structures that provide health services at the local level, education, living and employment conditions, family, food, water, hygiene, smoking, alcohol consumption, physical (in) activity are health or disease determinants on which action could be taken. Disparities in health status starting from validated indicators are broad, if we consider that half the country's population lives in rural areas, where hospitals are virtually non-existent (even *dispensaries* and pharmacies). The level of financing the health system in Romania remains low compared with the European context, but there are no studies on the effectiveness of the allocation of existing resources. There

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<sup>1</sup>Health sociologists benefit (in Germany) of significant funds for multiannual financing (at least 5-8 years) on the part of the German Foundation for scientific research (Deutsche Forschungsgesellschaft), from ministries of resort, etc. Federal Government launches research programmes relating to pregnancy, birth, postpartum period, cardiovascular diseases, etc. Ministry of Youth, Family and Health funds research for the discovery of certain risk groups, Health Insurance funds want to know how patients choose to enter the health care system, how doctors decide prescriptions and treatments, etc. and finance research in deterrence, functioning of health care services, etc. German doctors deem medical sociology a real and useful support in their job, unions of workers in the medical field resort to sociological research to gain information on the causes of diseases, factors, actors involved, to argue and conduct successfully specific actions. Sociologists in the field also collaborate with political parties that are interested in both profane and alternative medicine, pursue regular publications, and field-related manifestations.

<sup>2</sup> Results based on the indicators of health improvement, increased capacity of response to the expectations of the population, ensuring fairness in financial contribution etc.

are no appropriate functional links between primary and hospital care, or between disease prevention and healing. The principles of equity<sup>3</sup>, quality<sup>4</sup>, and responsibility of actions centred on patients are not always observed, and solutions are most often presented as *recommendations* or ... premonitions<sup>5</sup>. *Principles* tell us that the health system should be adaptable, capable of rapid response, to react effectively to the population's needs, at a reasonable cost. The report indicates that the system is built around central administration, medical staff<sup>6</sup>, and patients are deprived of the effective power to influence the system they provide money for. The report *recommends* the *reorganisation of the system, decentralization of decision-making and organizational quality assurance in health, as well as re-configuration of the health information system, restructuring and reorganization of hospital services, diversification of funding methods for hospital services, the development of new models of management, and improving composition setting list of drugs. Altering the rules for compensation and pricing, development of a system to monitor the prescribing and drug release, multidisciplinary primary care teams, improving the allocation of resources for primary care, diversification of services offered* etc. are also mentioned.<sup>7</sup>

The committee who drew up *The Report* concluded that *public health system in Romania presents major dysfunctions, with direct repercussions on the health state of the population, and that the actions of the system should be patient/citizen-centred* (Raport, 2008, p.63). There are confusions and controversies in the specialty literature regarding *the community, the development of the community* and their connection with the public health and health promotion. The intelligibility frame should refer to the community members' active participation in finding plausible solutions for the identified problems, taking in their own hands the control over their lives. Plausible data should be provided on the existence of health services in territorial communities, on the activities for improving the inhabitants' health state, significant changes in patients' behaviour,

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<sup>3</sup> Each individual should benefit from real opportunities to attain his/her health potential, if possible with no disadvantage (inequities refer to unjust, avoidable health differences )

<sup>4</sup> Quality improvement is linked to implementing international guidelines of acknowledged good practices, diminishing differences, attaining standards etc.

<sup>5</sup> *Premonition* means *pre-feeling* future facts and events, generally without rational arguments: the level of health sector funding in Romania *will* increase, the multiannual budgets *will* be generalized, foreign funds *will* be attracted, a system for resource allocation based on transparent criteria and medical records *will* be developed, multiannual funding reports *will* be published, the quality of medical services *will* improve, *will* diversify etc.

<sup>6</sup> Although doctors' performances are affected by *the presence of an insufficient system of motivation* (low income, poor working conditions, low career advancement opportunities).

<sup>7</sup> Financing and organizing health system, medicine policy, primary assistance, hospital services, human resources, etc. People need help to be healthy, to trust the medical system with organized and localized services depending on their needs and preferences. Everybody's preoccupation in reducing the inequities can lead to a bigger responsibility of each one for his/her own health.

in increasing self-awareness, self-esteem and hopes for the future (Campbell et alii, 2007).

## 2. Consulting patients

The opinions of population (Massé, 2005) should be illustrated at least by means of surveys (even if they are suspected of simplicity and simplification). If citizens, inhabitants are involved in the determining of priorities in the public health domain, their values should be analyzed (Litvas, 2002). The importance of *citizen participation* is reaffirmed in the legislation, which stipulates that even the public health plans should be made after their consultation (Contandriopoulos, 2004). The participation is not a universal remedy<sup>8</sup>, neither the privilege<sup>9</sup> of a minority. The participation is a moral duty when the community can benefit of the advantages, the benefits of the participation. The participation can contribute to the update of the values of autonomy, dignity, self-determination, even more if the deprived categories can participate and benefit from the results. *Elitists* can say that *ordinary citizens, simple citizens* are not *equipped* to contribute in making the decisions. Only directly from these citizens we can learn whether they have or not relevant knowledge in the domain. Some talk about *expert patients* (Wilson, 2001) which means becoming better informed, others about patients with *practical knowledge* or about citizens with certain *predispositions* which make plausible presuppositions regarding the acceptable health conditions, risk behavior etc. On the field, we can identify attitudes and values, convictions of a certain population towards a particular health problem, habits and associated behaviours (sometimes significant from one group-socioeconomic, ethnic, religious - to another), definitions of what is acceptable and unacceptable about promoting health and reducing suffering, as far as maintaining personal information confidentiality is concerned. Still on the field we can discover to what extent the patients' consulting is a necessary and sufficient condition to make proper decisions for improving the situation in the field of health attend, so it won't get to *the dictatorship of the uninformed*. The right to the consult must be associated with the obligation of the persons consulted to be solidary with the decisions established.

## 3. Doctor-patient relations

The interaction brought about by health care is not a spontaneous event, but a social meeting, a confrontation where the participants have learned to expect certain attitudes and behaviours and act in certain ways (Fainzang, 2002). The doctor and the patient have conceptions, perceptions, different attitudes, and

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<sup>8</sup> Remedy against all evil, saving solution in any situation (DEX).

<sup>9</sup> Material or spiritual good which belongs to someone (DEX).

among them could exist communication barriers, beside statute differences, ethnicity etc. Whoever is engaging in this relationship has to play the roles adequately: the doctor has to treat his/her patients equally, conforming to the profession's deontology, apart from personal relations; even if he/she has access to the patient's physical and psychical intimacy, he/she is interested on the strictly medical issues, not on the patient's private ones. The relation between patient and doctor is similar to the one between the child and the parent, or pupil and teacher. When the patient is not feeling well, he/she can decide alone if ill or not. If he/she believes he/she is ill, he/she can begin by treating himself/herself. The failure of the self treatment determines him/her to ask for help to the profane reference network (family members, relatives, neighbours, and internet). If he/she fails in this case too, he/she resorts to the doctor... At this moment he enters in the *professional device*. The more deeply he/she enters inside, the more he/she loses control, which is taken over by the doctor. Thomas Szasz and Marc Hollender (1956) were identifying more doctor-patient relation types : *passive patient* and *active doctor* (the prototype of the relation between infant and mother), the doctor having absolute control over the situation; *the patient accepts the doctor's authority*: he/she comes to the doctor knowing that he/she suffers, being ready to cooperate (the prototype relationship is the one between child and parents: they don't have absolute power, but they are using it *in the child's superior interest*); *the participation is reciprocal*, the patient can take care of himself/herself following the doctor's instructions, and the doctor helps the patient to help himself/herself (the prototype is the relationship between two adults, possibly between parent and teenager). The sociologist can analyse the doctor's and patient's behaviour, in order to emit adequate logics and find good practices, analyse expectations from the doctor, the doctor's expectations from the patient etc. The doctor-patient relationship is affected by the personality of the two, their statute, and their socio-demographical, cultural and religious characteristics. We cannot talk about the same model of behaviour of all the members of a social group; neither could we exaggerate the influence of the *collective tendencies* on an individual's behaviour. Patient's coming to the doctor and his attitude towards him/her are not far from the relation of the citizen with the authority in general, within a certain traditional social order, but the *submission* to the doctor is optional (the patients do not offer their lives to the doctor unconditionally, they can refuse the prescription, some are more *talkative* during the consult, ask questions, ask for clarifications on the disease, sufferance, treatment, and long term consequences).

Although the law guarantees patients the right to information, many times the doctors hide the real facts. Some say they do it out of *kindness*, with the purpose of protecting the patients (Fainzang, 2006), especially the sensitive ones, on the announcement of a threatening disease (or in the case of a *subtle diagnosis*). For others, hiding the truth is a weapon used in the therapeutical relation, with the

purpose of avoiding the disputes or to keep the patient in a dependent state...Doctors do not hide systematically the truth from all their patients. Sociologists distinguish sometimes a correlation with the patients' social origins (some doctors could have the prejudice that the patients who come from privileged milieu have the strength to handle the truth more than the ones who come from underprivileged milieu-even if they could be wrong about their reaction). Some doctors believe that the patients who don't ask questions, don't want to know the truth (even if, when questioned by a sociologist, the patients can answer that they refrain from asking because they do not want to upset the doctor, do not want to take too much from their *precious time* etc.).

But patients do not hide the truth from the doctor? Occasionally they hide alarming symptoms to avoid hearing an unwanted diagnosis (although if they provided correct, detailed information on the symptoms, conditions, social elements from the belonging milieu, the diagnosis could be a better one).

Efforts are being made to change a population's behaviour, to determine the members to adopt a healthy behaviour, to act for their own good (actions of *awareness, responsibility* etc.). The evaluation of the efficiency of such actions demands the comparison of knowledge, attitudes, and people's practices before and after spreading the messages (preventive or curative). These messages can be efficient if they are adequate to target-audiences, relevant in rapport with the pursued objectives. These can be addressed to individual members, to a group, the *group leaders, opinion leaders, of pilot-citizens*. The population is not homogenous, and the messages can be received differently by men and women, townsmen and villagers, illiterates and educated. They can target the constraint, people's *freight* (one of the methods still used to determine young women to make ante-natal visits to the doctor, for parents to get their children vaccinated, to make businessman stop advertising noxious products...). There is the departure hypothesis that people can be stimulated seeing or hearing a repeated media message (posters, audio-visual publicity) and, seduced, they will adopt the behaviours proposed. The vulgarization activities of knowledge regarding health and disease have as a basis the conception (*Manichaeism*) that people know to choose between truth and lie, that they start from values, from the *collective unconscious, socio-cultural patterns*<sup>10</sup>. Those who send such messages need to start from recognizing the symptoms(which can be simulated), rather than the illusion that the terms used are understood in the same manner<sup>11</sup>. The main reason

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<sup>10</sup> The medical personnel expresses itself in scientific language, their knowledge is based on and expresses through medical discourse, use written texts to articulate their knowledge, prescriptions, etc. The patients express through common language, have a basic cognition in the field based on experience, observation, predominantly oral etc.

<sup>11</sup> The doctor can see the disease as a "physical dysfunction", as an "organic or functional change of the normal balance of the body", while the potential patients from the "traditional" milieu can consider it "a divine punishment", "misfortune", sign of the social disorder, etc.

is, for all those involved, the prevention of diseases, their healing, only that the doctor talks about *the control of risk factors*, while the potential patients talk about *God's will* etc. The hope of changing the behaviours through *good messages* starts from the belief that medical discourse can transform patients' practices. This hope needs to have as support: *information* – to modify the patients' social representations (which can be parallel with the medical discourse), starting from the knowledge identification they have, from their practices (alimentary, prevention, protection, etc.); *change of environment* where patients live, improving living conditions, including the underprivileged ones (how could we talk about the necessity of the periodical consult of the health state of people from communities without a health center, pharmacy, with patients living very far from hospitals, from the city?); *formation* – which presupposes methods, specific logistics, etc. We can live with the hope that we will create the most adequate message and we will use the best way of sharing it to influence behaviours, provided that doctors understand patients' requirements, and patients grasp the logic of the medical approach.

#### 4. Patients' satisfaction to the quality of the family doctor's cabinet

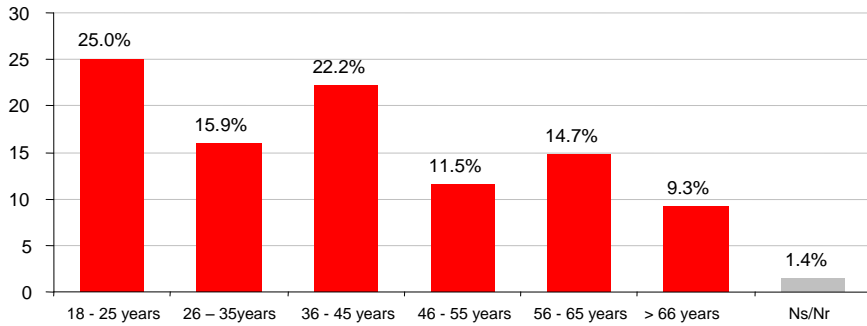
After identifying the addresses of all the family doctors in the city (about 400 cabinets), we have established the multi-stratified, possible (maximum error admitted  $\pm 3\%$ ) sample (180 cabinets, 496 patients). We have formulated the questions (together with responsible doctors from the CAS<sup>12</sup>) that we were to address to the patients<sup>13</sup>. In 2011 and 2012 we have gathered accessible information from the patients' cabinets to identify the level of satisfaction towards the quality of the services. Respondents to the questionnaire: 58% men, 42% women, aged between:

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<sup>12</sup> Health insurance company

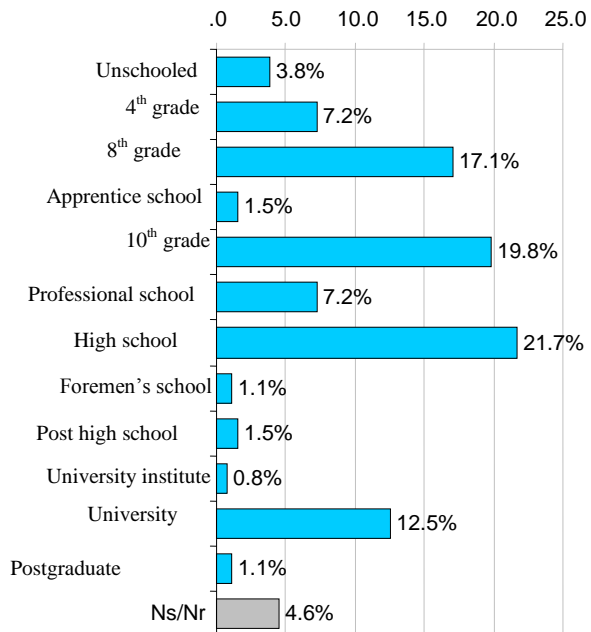
<sup>13</sup> *How much importance do they give to health care? (Very little, Very much, Very much importance). Is the family doctor important for you? (Very little, Important, Very important) Are you insured at the CAS? Do you know your rights and your obligations as a member? Are you on family's doctor list? Have you changed the family doctor? (if yes, why?) Do you make an appointment to the family doctor? Is the cabinet's timetable accessible? How long do you wait for the doctor to see you? Do you go the cabinet for: consult? referral to the specialist? to the hospital? What grade (from 1 to 10) do you give to the cabinet's reception and cleanliness? Do you appreciate that the posters, advertising panels and indicators are useful? what grade do you give to the nurse's behavior and attitude? What grade do you give to the doctor's behavior and attitude (kindness, availability)? Do you have the feeling that you are being taken care of? Does the doctor give you enough information about your health state? Does he answer your questions clearly? Have you offered material gains? (if yes, you did it because: were you asked to? is it used to? out of gratitude? ) how do you appreciate the safety offered by the medical tools and their handling? Is it hard for you to get the recommended medication? Are you prevented about the medication's side effects? List some weak and strong points of the family medicine. Could this get better?*



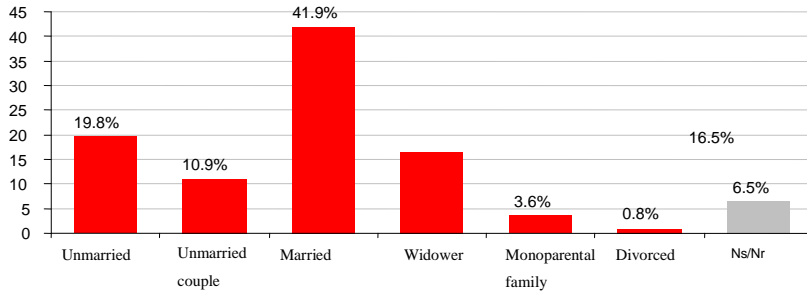


95% of the respondents were living in the city capital of the county (where the family doctors' cabinets and CAS were). 98% of the respondents declared themselves as being Romanian citizens (1.8% have mentioned being of gypsy ethnicity).

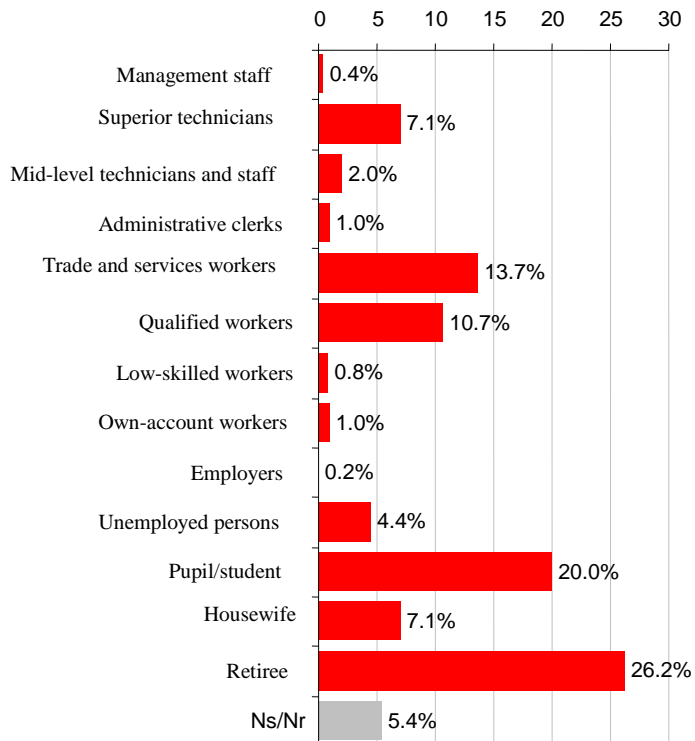
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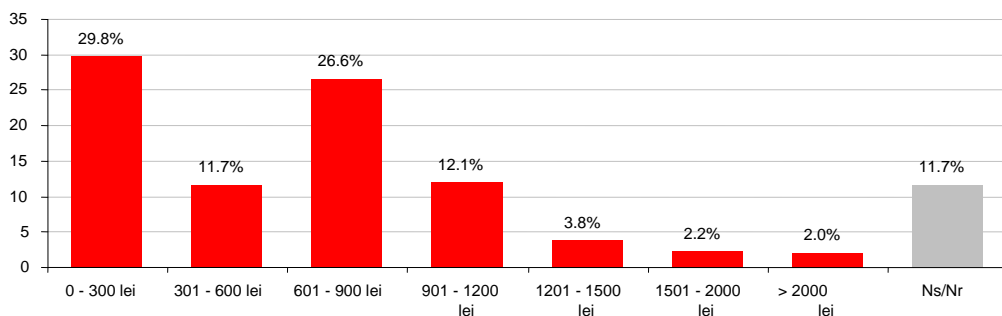
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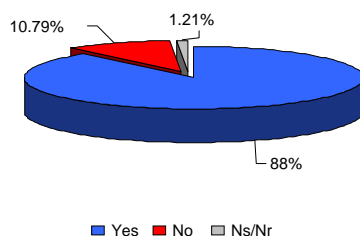
Activity:



Income (declared):



At the question regarding the importance they give to the health care, 36% of the patients who answered our questions declared *enough importance*, 25% *very much importance*. 20% *great importance*. The majority of the questioned patients are preoccupied with their health care (88% give *great importance*<sup>14</sup>). 88% of the questioned patients at the family doctors' cabinets were insured at the CAS.



65% respondents declared that they are aware of the rights and obligations implied by being CAS member. The insured have the right to a basic services package; this package, the list of the care services – including the ones at home, the list of medicines, medical devices and other services for the insured, allotment of resources and cost control, prices, but even the information method of the insured and the dimension of the co-pay are established based on the frame-contract<sup>15</sup>; the insured can choose the medical service supplier (handling the transportation expenses if they want another doctor from a different locality),

<sup>14</sup> *The national society of family medicine* is a professional, scientific, nongovernmental organization, apolitical, private law, with judicial personality, constituted of county organizations with judicial personality of the family doctors.

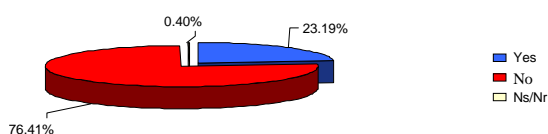
(<https://www.facebook.com/Societatea.Nationala.de.Medicina.Familiei>);

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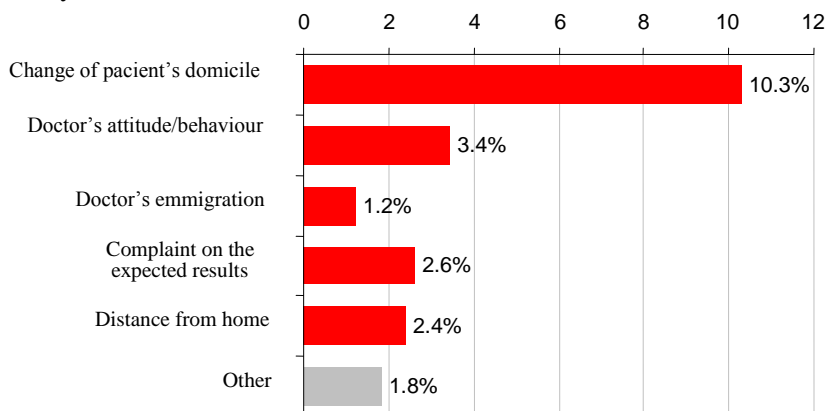
<sup>15</sup> Released by the CNAS after consults with the Doctor's League from Romania, The Dentists League, The Pharmacists League, The Nurses and Midwives Order, The Biochemists Order, Biologists and Chemists, as well along with patronal organizations and syndicalism.

they can choose the health insurance company, change their family doctor, benefit from medical services, medicine, sanitary materials and medical devices without being discriminated, benefit from prophylactic controls, preventive and promoting medical assistance services, itinerant medical services and in hospitals that have contracts with the CAS, urgent medical services, some dentistry assistance services, physiotherapeutic and recovery services, residence health care; the insured patients have the right to be guaranteed personal data confidentiality (mostly regarding the diagnosis and the treatment), to be informed in case of medical treatments, etc. The obligations of the insured are to register on a family doctor's list<sup>16</sup>, to let the doctor know each time changes occur in their health state, to come to periodical and prophylactic controls, to announce the family doctor and the CAS if there are identity changes 15 days prior, to have a civilized conduct towards the medical and sanitary personnel, to pay the debt owned to the fund.

*Have you ever changed your family doctor?*



*If yes, why?*



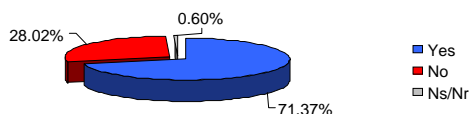
Health is a priority, which is the reason why people seek the best methods, ways and doctors to take care of them. 98% of the questioned patients were registered on the family doctor's list. The family doctor knows well patients' medical history, has a record of their health state. According to the Health Insurance Company, only the persons with insurance can change their family doctor after a

<sup>16</sup> <http://stirileprotv.ro/stiri/sanatate/listele-de-pacienti-sunt-vandute-ca-la-piata-in-romania-cat-valoreaza-cnp-ul-tau-pentru-un-medic.html>

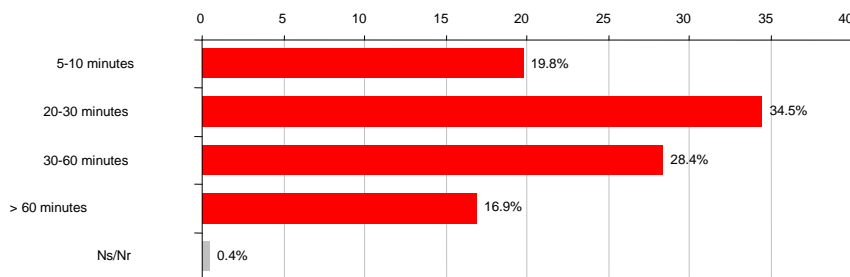
period of minimum six months from the registration on the doctor's list. The insured can address an application to the doctor on whose list they want to register (where they specify the name of their present doctor). After the record of the application, the receiving family doctor has to announce the other family doctor, in maximum 15 working days, as well the CAS with whom has a contract. The medical record of the patient will be sent to the new family doctor (a copy will be kept at least a year at the medical cabinet from where the patient has left). The patients will give the family doctor a certificate that proves their quality of insured of the Health Insurance Company. The retired persons can show the pension coupon<sup>17</sup>.

*Do you make an appointment to the family doctor?*

The family doctors have a working schedule of five hours at the cabinet and two hours of consult at patients' residence (the cabinet hours can be prolonged in the case when the number of patients who preferred the respective family doctor goes over 2200-3000). The doctor's schedule is posted as well as the telephone numbers for appointments, to contact the CAS, the emergency call<sup>18</sup> etc.



*Is the cabinet's schedule accessible? How long are you waiting to be seen by the doctor?*

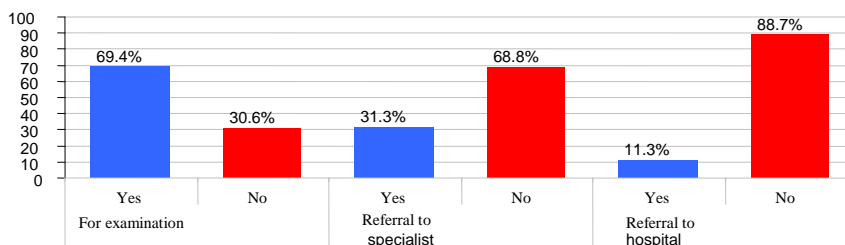


<sup>17</sup> [http://www.avocatnet.ro/content/articles/id\\_27716/Cum-iti-poti-schimba-medical-de-familie.html#ixzz2iH1FZdqz](http://www.avocatnet.ro/content/articles/id_27716/Cum-iti-poti-schimba-medical-de-familie.html#ixzz2iH1FZdqz)

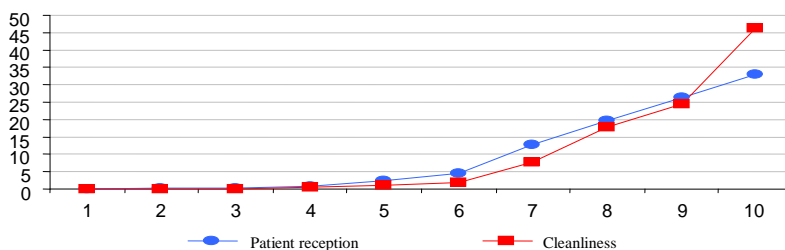
<sup>18</sup> The doctor's code can be posted at the cabinet, or on [www.callmed.ro](http://www.callmed.ro). Some doctors accept patients to contact the medical advisory phone service. 1363 is the telephone number where the patients can call the family doctor at any hour of day or night, if the patient is registered in a Family Doctors Employers program. Instead of calling the emergency number 112, in the case when health problems aren't urgent, the patient can talk directly with the doctor that has been treating him for years.

At present, the Health Ministry wants economy by lowering to 40% the number of hospitalizations. Since the number of doctors is not sufficient, criteria have been already established for patients' schedule. For example, if a pregnant woman with heart condition can wait to two weeks to a consult, a child that has a stomach ache could wait to two months, a couple who does not have children has to wait to half a year for a consult, and a patient with sudden deaf-14 days<sup>19</sup>.

*Why do you go the family doctor's cabinet?*



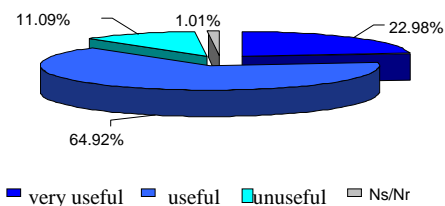
*What grades would you give to the medical personnel and cabinet cleanliness?*



The functioning authorization of medical cabinets is released based on the self-responsibility of the legal figurative of the cabinet. The family doctors have the role of coordinators and monitor not only the patient's treatment, but other activities as well (prophylaxis, information etc.). To assure a quality medical consult, the doctors need to have access to specialty information, to have specific endowment with medical devices. Many cabinets don't even have the minimum endowment (according to 153/2003 Order issued by the Ministry of Health and Family), which means: apparatus to measure blood pressure with stethoscope, baby scale, waist meter, pelvis meter, negatoscope, tongue depressor, mouth opener, reflex hammer, nozzles, Guyon syringe for ear leverage, Kramer splints etc.). There is a wider variant of the apparatus, instrument, sanitary materials and necessary medicine to give first aid at the level of the family doctors' cabinets.

*Are posters, advertisement panels on the hallways, cabinets useful?*

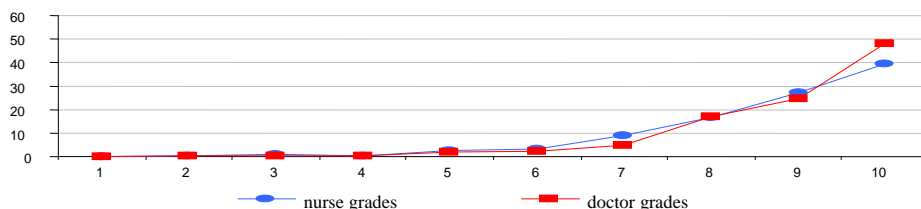
<sup>19</sup> <http://www.replicaonline.ro/a-decedat-in-sala-de-asteptare-in-timp-ce-medicii-de-la-iowemed-l-au-ignorat-125696/>



The entrance in a sanitary unit can inspire confidence or can lead to doubt... The hallway should be bright<sup>20</sup>, clean, with comfortable chairs where the patients and their companions can rest. The ambiantal environment should make them feel comfortable and welcome, be civilized, friendly, to encourage the patients. People feel valuable in friendly places, with close but strict personnel, which develop positive inner feelings. The hallway, the cabinet need to have identity, to be the places where the patients already feel better. These places should have indication panels that help people orient, accessible poster panels, written big enough and legible, with important messages, which reflect medical culture, inclusive politics, to train their intellectual capacities, to make them interested, curious. The methods of arranging the room of the family doctors' cabinets are described in any specialty publication (which publishes law texts regarding medical cabinets: the Governments Ordinance 124/1998 republished through Law 629/2001, Law 31/1990, Ordinance 26/2000, etc.). It is understood that there are no prescriptions and many things depend on science, art and the domestic spirit of family doctors.

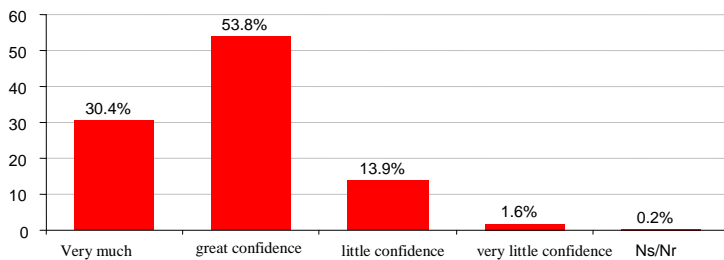
*What grades do you give to the nurses' and doctors' behaviour and attitude?*

If patients' *competences* increase, their exigencies can increase and their docility towards the doctors can decrease ... *World Medical Association Declaration on the patient's right* foresees the right to quality medical health care, to his own choice of the doctor, certain doctor's behaviours in the case of an unconscious patient, minor, without discernment, patient's right to information, sanitary education etc.



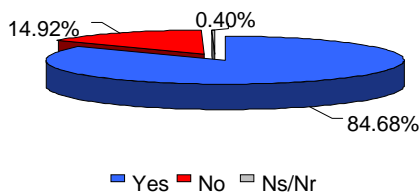
<sup>20</sup> <http://www.opiniatimisoarei.ro/locul-unde-timisoreni-se-duc-sa-moara-centrul-de-ingrijire-paliativa-ultima-linie-intr-un-razboi-deja-pierdut/24/04/2013>

*Do you trust your family doctor?*

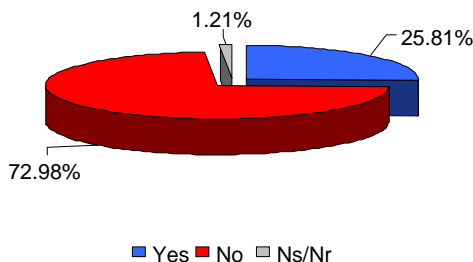


Patient’s trust in the family doctor depends on his/her constant interactions, on the notice of some improvement signs of his/her health state after doctor’s intervention, on the doctors’ system professionalism, to whom he appealed and interacted with, on the fact that he/she feels the doctors’ effort to help, inform, and be responsible of his/her health. Patient’s confidence level in the doctor is linked to the trust level in the medical services, in the Romanian medical system (many got used to system’s insecurity problems starting from the previous experiences in the contact with this system...).

*Is the doctor offering you sufficient and clear information regarding your health state?*

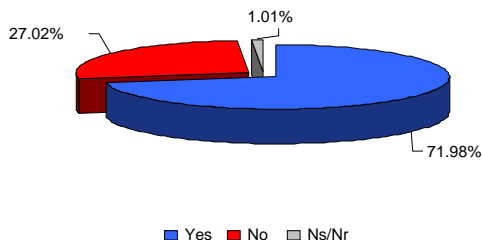


*Do you obtain hard your medicine?*



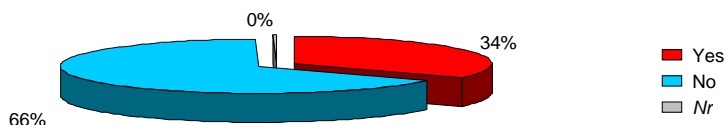


*Are you prevented about the medication's side effects?*

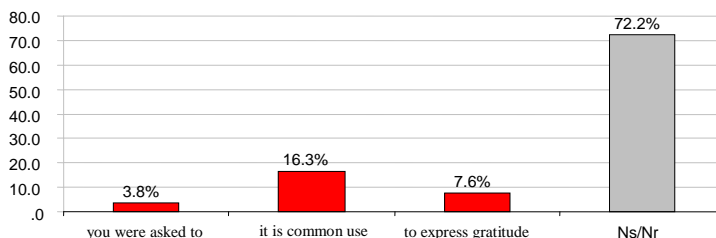


Many patients take medication without being consulted by a doctor<sup>21</sup>, especially when it comes to minor affections (head aches, sore throat). When they have a more serious problem, many patients admit that they take medication that made them feel better in other situations...Patients are mistaken if they do not observe the administration time and interrupt the medication if they feel better, because the risk of recurrence is increasing. Many patients do not even read the prospect. When doctors prescribe medication, they take into consideration associated affections, medication, and make individualized therapeutic schemes etc.

*Have you ever offered any material use to the medical personnel?*



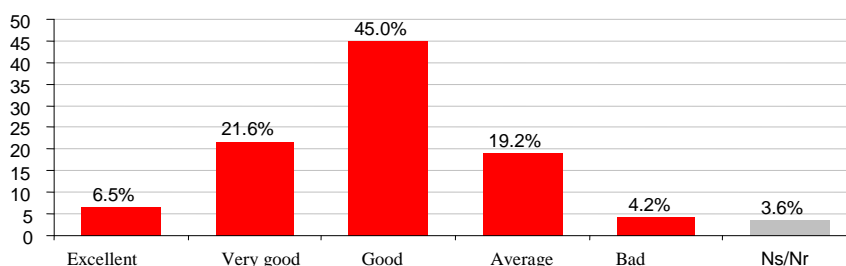
If yes, have you offered because:



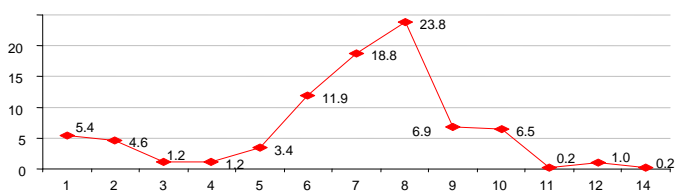
<sup>21</sup> [adev.ro/mobwge](http://adev.ro/mobwge)

Another survey<sup>22</sup> shows that 63% of the questioned have bribed<sup>23</sup> the medical personnel: theoretically, there should be an equilibrium sign if a third of the population is satisfied by one of the most criticized public systems in the last 24 years. If we think that a little over a third of the same population admits that has a good health state, may not have had much contact with the system. The displeasure is focused on the real beneficiaries of the health system, those who, eventually, know it better after the direct contact. Patients questioned in the mentioned survey declare that they have offered gifts or money, they say that they've given of their own will (66.6%), they have been asked to (31.4%). On the other side, 73.5% think the doctors aren't well paid and they leave the country because of their salaries, the comfort lack in Romanian hospitals and 10.4% out of will of working in another country<sup>24</sup>.

Questioned patients' perception on their own health state:



The average hours of sleep per day:



Sleep is essential for health, and the necessary hours of sleep differ depending on age and sex. Doctors say that it is recommended to sleep 6 to 9 hours per night, between 10 PM-04:00 AM<sup>25</sup>. Over 30% of the medical problems that the doctors

<sup>22</sup> Made by *INSCOP Research* called “The Barometer of Public Opinion-The Truth about Romania”, during April 20-28 2013, on a sample of 1050 persons, the maximum error admitted being +/- 3%, and the trust degree 95% (<http://www.inscop.ro/>)

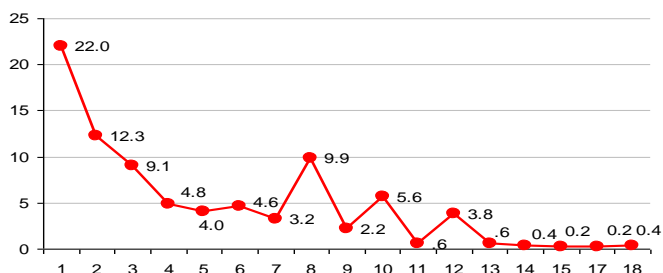
<sup>23</sup> Bribe, tips (Rus., *șpagă*).

<sup>24</sup> <http://www.ziare.com/articole/spaga+medici>; <http://www.piatadespaga.ro/spaga/sanatate-medicamente/pag16.html>

<sup>25</sup> Phyllis C. Zee from *The Center for Sleeping Trouble* from the Northwestern University Chicago (<http://www.everydayhealth.com/>).

identify at their patients start from sleeping, but sleeping was ignored in doctors' training and there are insufficient centers where it is studied today. Among the factors that disturb sleeping there are hormonal trouble, depression, emotional problems, sleep apnea, back pains, fibromyalgia. Specialists advise those who have trouble sleeping to establish a schedule that they have to respect each evening, with no physical exercise before sleeping, no coffee after 6:00 PM, a medium temperature in the bedroom, dark, silence.

The average number of physical activity hours per day:



Doctors recommend at least 30 minutes of physical activity (moderate intensity) per day, to prevent and treat obesity, tonus stimulation and mental capacity, removing insomnia, reducing the risk of cardiovascular diseases, to increase resistance to infections, to instate the *well being state* by releasing endorphins etc. to be more precise, walking is recommended (5-7 km/h), fitness, aerobic, swimming, climbing stairs, etc. For many people, the main obstacle in practicing is lack of time. But some exercises could be practiced during the day, in stages, in lunch breaks, in friends' company, family members, shopping, giving up the car, and using public transportation.

In august 2013 there weren't (many) complaints of the CAS insured from the range of whom patients of the questioned family cabinets were selected<sup>26</sup>:

Fields of medical services	TelVerde Calls	Audiences	Claims	TOTAL
Removing the insured patients from the list without their consent	22	2	7	31
Complaints about quality of care			1	1
Complaints about home care		5		5
Care for persons with no income	35		12	47

<sup>26</sup> [ww.hih.ro/index\\_cas\\_w.php](http://ww.hih.ro/index_cas_w.php)

Otherwise, they have listed especially *the strong points* of the family medicine: accessibility, communication and good collaboration between doctor and patient, on-time discovery of some affections, easy access to the recommended specialized doctor. There have also outlined the trust in the medical personnel, availability, kindness etc. *The weak points* are the insufficient room, the equipment, the big number of patients at a family doctor, the medication price, the extra cost.

*The laws:* 95 from April 14<sup>th</sup> 2006, 34/2007, 157/2008 etc., as well as *emergency ordinances* of the Government: 72/2006, 116/2006, 264/2007, 90/2007, 93/2008, 170/2008, 197/2008, 104/2009, 114/2009, 48/2010, 212/2011, 257/2011, 71/2012 etc. show the preoccupation for reglementation inside the health system, the compatibility of the Romanian legal framework with the existing one at EU's level. And still, many Romanians (with opportunities) appeal to medical services from other countries. Many doctors and nurses leave the country<sup>27</sup>. Patients who go to Vienna, for example, because everything there is clean *like a pharmacy*, spaces do not smell like hospital, colours are nice, you do not have an unfriendly feeling (given by many medical spaces in Romania); there are also special chairs for patients with hip prosthetics so they can sit down without the fear of breaking their prosthetics, there is internet connection and wireless internet for patients, there is a TV in every room, radio, patients have a remote at their bed side, to turn the light on or off, to call the nurse<sup>28</sup> etc. If the patients commit themselves, they receive a bar code (which is written on the bracelet attached at their wrist, on the boxes with medication, at the bed side, on the paper sheets on the table, on the analysis papers or of the medical procedures), they are registered to ratio from the moment they are admitted, they can choose the menu, they have at their disposal toilets and impeccable showers, liquid soap is never missing, as well as sanitizer, tissues, toilet paper. The University Hospital from Vienna spreads on a surface of 240 000 square meters, comprising thousands of research laboratories, thousands of doctors, twice as many nurses, 2 200 beds, 51 operation rooms, recent investments of over 80 million euros. The hospitalization cost is 900 euros per day, to which added the cost of analysis, of operation, and of ulterior treatment. The Austrian medical system is considered the best in Europe<sup>29</sup>. The word bribe does not exist in Austria<sup>30</sup>...

<sup>27</sup> <http://www.soros.ro/ro/publicatii.php?cat=15#> (*Al Patrulea Val. Migratiacreierelorperuta Romania-Occident*)

<sup>28</sup> <http://edeir.ro/in-ce-tara-merg-romanii-sa-se-trateze.html>

<sup>29</sup> <http://www.wall-street.ro/slideshow/International/119111/care-sunt-tarile-care-au-cele-mai-mari-cheltuieli-cu-sanatatea/3/austria.html>

<sup>30</sup> [http://adevarul.ro/news/societate/austriaradiografia-unui-sistem-sanatate-funcional-1\\_521e35b1c7b855ff56218b87/index.html](http://adevarul.ro/news/societate/austriaradiografia-unui-sistem-sanatate-funcional-1_521e35b1c7b855ff56218b87/index.html)

*What could improve our system?*

The answers included increasing the number of cabinets, endowment, increasing the number of doctors, optimizing the schedule, reducing services' cost, improving the conditions in the waiting rooms, etc. *The Development Strategy for Primary Care in Romania (2012-2020)* in agreement with the stipulations of *World Congress of Family Doctors (WONCA World)*, of the *National Society of Family Medicine*, concerns to improve the access to primary quality medical care, creation and maintenance of a favorable environment to lead to a better health care of the inhabitants. The family doctors must offer services for persons from the family, community, groups, respecting patients' autonomy. They need to be preoccupied of: promoting health, disease prevention, provide treatments, promote the *empowerment* (self discipline and patients care from self)<sup>31</sup>. Primary medical assistance has developed in the last 23 years. Many attending doctors could become family doctors after supplementary training courses, exams and residency programs. In 2010, The Health Insurance Company from Romania had concluded contracts with approximately 11 400 family doctors who had become (by the social health insurance Law) suppliers with competencies and revised and improved responsibilities. Patients trust family doctors and respect them<sup>32</sup>, with all the problems linked to policies from the health domain, financing, organizing and services supply, of human and physical resources. It is necessary the increase of family medicine efficiency and quality through:

- the assurance of adequate planning of necessary human resources;
- the assurance of sustainable salaries, promising of performance;
- the improvement of the offered quality service;
- the improvement of access for the isolated rural areas ;
- stimulation of the local authorities involvement;
- organization of practical probations in the rural environment for the medicine students and resident doctors in the family medicine;
- reduce the bureaucracy in cabinets;
- introduce the performance criteria in the Framework Contract etc.

The questioned patients do not want a chaotic health system, where money is never enough, medication is missing, equipments old and doctors are always in a hurry...Nobody wants hospitals in ruin, in bankruptcy and where the patients need to buy their own medication, bandages etc. even if they are insured<sup>33</sup>. They want a sanitary system centered on patients' needs.

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<sup>31</sup> The European definition for family medicine (WONCA, 2011).

<sup>32</sup> Technical assistance for the Management Unit of the APL 2 Project from the Health Ministry of Romania, with the purpose of developing a Strategy for primary medical assistance from unprivileged areas and of the afferent Action Plan, Final Rapport elaborated by T. Chanturizde, February 2012.

<sup>33</sup> <http://stirileprotv.ro/stiri/romania-te-iubesc/romania-te-iubesc-sanatatea-e-in-coma.html>  
<http://stirileprotv.ro/stiri/romania-te-iubesc/romania-te-iubesc-de-ce-e-in-colaps-sistemul-sanitar.html>

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28. <http://www.ziare.com/articole/spaga+medici>;
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