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Psychosocial evaluation of physicians receiving adaptation training in family practice*

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Aim: To identify the psychosocial conditions of physicians who received the first phase of the transition period adaptation training for family medicine practice in Bursa, and develop an efficient and reliable scale to take measurements during subsequent training processes.

Materials and methods: A pilot test was given, using survey methodology, to physicians (442 people) who attended the first phase of the transition period adaptation training for family medicine practice in province of Bursa, Turkey, in 2008. The survey questions were designed to assess 3 factors: A- Adaptation to the program, B- Occupational self-confidence, and C- Non-exhaustion. Each factor was represented by 10 to 11 questions. A 5-point Likert-type scale was used for assessment (I-Strongly agree, II- Agree, III-Neither agree nor disagree, IV- Disagree, V-Strongly disagree.). Questions involving age, gender, length of professional experience, opinions about the training, knowledge and opinions of the family practice system, as well as views about the future work practice of each participant were asked. The contents of the 31-question survey to be used for the Pilot Test, along with its validity in terms of scope and content investigated, taking the views of 3 specialist doctors. Then, the survey was given to 442 doctors who participated in adaptation training, both before and after the training program. The results were analysed using the SPSS (Statistical Package for the Social Sciences) program. Reliability analysis was performed for all the factors in all 31 questions. Having removed the questions lowering the reliability in each factor, the remaining 17 questions were classified in 3 factors, by applying Factor Analysis (Quatrimax Method).

Results: Two hundred seventy-one male (61.3%) and 171 female (38.7%) physicians participated in the survey. Mean age and length of professional experience was higher in males than females. While the majority of the participants (72%) thought the training they received was just an activity that would improve their adaptation, a small percentage (7.9%) thought that it would increase their professional competence. Statistically speaking, mean occupational self-confidence factor scores were higher in post-training tests compared to the mean scores before training ($P < 0.001$).

Conclusion: Findings show that the first phase of the transition period adaptation training for family medicine provides a positive beginning and psychosocial improvement for these family medicine practitioners.

Key words: Family practice, adaptation training, psychological effect, assessment scale

Aile hekimliği uyum eğitimi alan hekimlerin psikososyal açıdan değerlendirilmesi

Amaç: Bu çalışmanın amacı, Bursa'da aile hekimliği uygulaması geçiş dönemi birinci aşama uyum eğitimi alan hekimlerin eğitimle ilgili psikososyal durumlarını belirlemek ve bundan sonraki eğitim süreçlerinde ölçüm yapabilecek geçerlilik ve güvenirliği belirlenmiş bir ölçek geliştirmekti.

Yöntem ve gereç: Türkiye, Bursa ilinde, 2008 yılında, aile hekimliği uygulaması birinci aşama uyum eğitimine alınan hekimlere (442 kişi) anket yöntemi ile pilot test uygulandı. Anket soruları üç ana faktör üzerinde oluşturuldu; A-Programa

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Uyum, B-Mesleki Özgüven, C-Tükenmemişlik. Her bir faktör, 10-11 adet soru ile temsil edildi. Değerlendirme için 5 şıklı Likert tipi ölçek kullanıldı (I-Kesinlikle katılıyorum, II-Katılıyorum, III-Kararsızım, IV-Katılmıyorum, V-Kesinlikle katılmıyorum). Her katılımcının yaş, cins, meslek yılı, eğitime bakışı, aile hekimliği hakkındaki bilgisi, aile hekimliği sistemi hakkındaki kanaati ve mesleki yönden geleceğe bakışlarını belirleyen sorular da sorgulandı. Pilot Test için kullanılacak 31 soruluk anket formunun içerik ve kapsam yönünden geçerliliği 3 uzman doktorun görüşü alınarak araştırıldı. Daha sonra, anket uyum eğitimi alacak olan 442 doktora eğitim öncesi ve sonrası uygulandı. Sonuçlar SPSS istatistik programında değerlendirildi. 31 Sorunun tümünde, bütün faktörler için güvenilirlik analizi uygulandı. 31 tutum sorusu içerisinde güvenirliği düşüren sorular anketten çıkarıldıktan sonra geriye kalan 17 soruya Faktör Analizi (Quatrimax Yöntemi) uygulanarak, 3 faktör altında sınıflandırıldı.

Bulgular: Ankete 271 erkek (% 61,3) ve 171 kadın (% 38,7) hekim katıldı. Yaş ve meslek yılı ortalamaları erkeklerde kadınlardan daha yüksek idi. Katılımcıların çoğunluğu (% 72), aldıkları eğitimin sadece uyumlarını artıracak olan bir etkinlik olduğunu düşünürken, az bir bölümü (% 7,9) mesleki yeterlilik sağlayacağını düşünmekte idi. Mesleki Özgüven faktörünün eğitimden sonraki ortalamaları eğitimden önceki ortalamalarından istatistiksel olarak daha yüksekti ($P < 0,001$).

Sonuç: Bulgular aile hekimliği uygulaması geçiş dönemi birinci aşama uyum eğitimlerinin, aile hekimlerine olumlu bir başlangıç ve psikososyal iyileşme sağladığını göstermektedir.

Anahtar sözcükler: Aile hekimliği, uyum eğitimi, psikolojik etki, değerlendirme ölçeği

Introduction

Within the scope of the "Health Care Restructuring Project", physicians who would like to work in primary care as family physicians without specialised training in this field were required to complete the "Transition Period Training" organized by the Ministry of Health, in order to familiarize them with the principles of family practice before practising in this field. The purpose of this training was to equip the practitioners and specialists who work or will work as family physicians with the necessary minimum knowledge, attitude, and skills. This transition period training included a 10-day course on the basic properties of the primary health care in family medicine, and then training for 1 year in which training and coaching methods in the workplace will be used (1).

In the description section of the 2nd article of the "Law on the Pilot Application of Family Medicine, No: 5258", a primary care physician is defined as a "family medicine specialist or any specialist or medical practitioner who has been trained through The Ministry of Health education programme, and who is responsible to provide comprehensive and continuous preventive medicine services directed to the public; primary care diagnosis, treatment and rehabilitation health services regardless of age, gender, and disease in a certain place; to provide mobile health service when necessary; and working on full-time basis" and the trainings for the transition period are based on this article (2).

Article 15 in the first section of 3rd part of the "Regulations Relating to the Family Practice Pilot Project" dated 06.07.2005 and numbered 25867, which was issued after the law mentioned above, states that primary care physicians and family health personnel are obliged to raise service quality standards by participating in the first and second phases of training, and at least 80% of the annual in-service training directed to family practice. Article 19 of the same regulation states that the training of family physicians will be carried out in 2 phases. The duration of the first phase of the transition period adaptation training for family medicine will be at most 10 days. The second phase will be modular and is in the form of an ongoing medical education (3), which begins after the first phase and lasts for at least 12 months. The duration and coverage of the first and second phase training are determined by the Ministry of Health. Family medicine specialists do not have to participate in the first and second phase training. Family medicine specialists may be included in in-service training alongside other authorized physicians at times determined by The Ministry of Health. Family physicians and family medicine practice staff have to attend at least 80% of these training activities (4).

Exhaustion in the work place has been put on the agenda through various studies performed on various profession groups. According to the definition accepted by Maslach et al. (5), exhaustion has 3 components: emotional exhaustion, desensitization, and decrease in individual feelings of success.

In this study, we aimed to use a survey that would be able to identify the psychosocial states of the physicians who receive the transition period adaptation training in relation to this training in Bursa province in Turkey, and to develop a scale with defined validity and reliability that allows measurements in subsequent training processes.

Materials and methods

In this study, in order to evaluate the psychosocial effects of the environment, we applied a pilot test to physicians (442 people) who attended to the transition period adaptation training for family medicine practice in 2008 in Bursa with a survey method. A pilot test was developed to obtain a valid and reliable scale to measure the psychosocial effects of training. Ethical Committee approval was obtained for the study.

Factors in the survey questions were identified as follows: Factor A: Adaptation to the training program; Factor B: Professional self-confidence; Factor C: Non-exhaustion. In order to get coherent results with other factors, we measured non-exhaustion instead of exhaustion. Every factor is represented by 10 to 11 positive and negative questions in the survey. Answers to the questions were assessed with a 5-point Likert type scale, as follows: I-Strongly agree, II-Agree, III-Neither agree nor disagree, IV- Disagree, V-Strongly disagree. The factors of the questions with negative answers were calculated by subtracting from 6. Furthermore, questions involving age, gender, length of professional experience, opinions about the education, knowledge about family practice, and expectations in terms of professional manner were also included.

Coverage and validity of the questions in the survey that was used as the pilot test were studied with 3 specialist doctors (Table 1). Later, survey was completed by 442 physicians before and after the training. SPSS (v.13.00) was used for all statistical analyses (6,7).

In order to evaluate the structural validity of the survey, we carried out reliability and factor analyses. First of all, we carried out a reliability analysis of 31 attitude questions classified in 3 factors (Table 2a). After excluding the questions with low reliability from evaluation, we applied factor analysis to the remaining 17 questions using the Quatrimax method (Table 2b). The Cronbach values of the factors varied between 0.631 and 0.733. Then we statistically tested whether the questions in the pilot test predicted the factors we had assumed at the beginning, and related to that factor by the respondents or not. In this way, the 17 questions were classified under 3 factors. In order to exclude unnecessary information, we suppressed factor loads under 0.4 (8).

Factor analysis revealed that the attitude sentence number 28 ("I know how to approach the people who will be affiliated with me"), which we predicted to be represented in "Factor A: Adaptation to the training program" should be in "Factor B: Professional self-confidence". After correcting the classification of this question, based on this finding, we repeated the reliability analysis. This time, the general reliability of the survey increased to 0.766 (corrected, 0.771). These values can be interpreted as "quite" reliable. The scale obtained in this way is named as "The Family Practice Adaptation Training Psychosocial Assessment Scale" (Table 2c). After completing the reliability and factor analysis, pre- and post-training score evaluations of the scale were carried out using Wilcoxon-dependent group analysis, and multifactorial analysis was carried out using Spearman correlation methods. P values < 0.05 were considered to be statistically significant.

Results

Two hundred seventy-one of the participating physicians were male (61.3%) and 171 were female (38.7%). The mean age of the male participants was higher than females (Table 3).

In pre-training surveys, the majority of the participants (72, 17%) thought that training would increase their adaptation, and a small percentage (7.92%) thought that it would provide professional proficiency. Some participants (19.91%) stated that they participated in the training because they were obliged to participate (Figure 1).

Table 1. Family Practice 1st phase training evaluation pilot test.

A-	**ADAPTATION TO THE PROGRAM**
1-	I feel adapted to the new application
4-	I am committed to the Family Practice application
7-	There are questions in my head related to the process N
10-	I do not understand what Family Practice is N
13-	I consider myself as a part of the system
16-	The Family Practice system is quite appropriate for me
19-	The Family Practice system confused me N
22-	I have no problems about the process
25-	The success of the system depends on us
28-	I know how to approach the people who will be in my care
B-	**OCCUPATIONAL SELF-CONFIDENCE**
2-	I feel qualified to handle all kinds of health problems
5-	I can monitor chronic diseases like Diabetes Mellitus and Hypertension
8-	I cannot manage complicated patients N
11-	I have sufficient knowledge and experience of many diseases
14-	I can easily perform the distinctive diagnosis of a patient who has come in for the first time
17-	I briefly look at the patients, and then send them to another physician N
30-	I can perform the treatment and follow- up of the people who will be my patients completely
23-	I know how to use every kind of individual preventive medicine
26-	Since I have no hospital experience, I cannot be very effective clinically N
29-	I can give full information to the patients about their illnesses
C-	**NON-EXHAUSTION**
3-	It is hard to change negative work conditions N
6-	I feel hindered in my professional life N
9-	I can handle the obstacles in my professional life
12-	I cannot express myself with regard to the problems in my professional life N
15-	I don't think that I can change the things that go wrong in my professional life N
18-	I feel that I have lost my ideals in my professional life N
21-	I have good ideals related to my professional life
24-	I have started to lose my desire to help people N
27-	I feel that my energy for work is decreasing N
20-	I try to avoid the problems at the office N
31-	I struggle with the problems at the office

Note: We calculated the scores of questions having N in the end by subtracting from 6.

Table 2a. Family Practice 1st phase training evaluation survey table of reliability analysis (obtained in SPSS using reliability analysis method).

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.766	0.771	17

Item-Total Statistics				
	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
AB15	54.84	74.704	0.299	0.759
AB18	54.76	73.514	0.315	0.758
AB21	54.26	72.064	0.340	0.757
AB20	54.31	75.747	0.236	0.765
AB27	54.66	70.213	0.455	0.745
AB2	54.52	73.488	0.383	0.752
AB5	53.86	75.660	0.342	0.756
AB23	54.90	74.705	0.307	0.758
AB29	53.90	75.529	0.366	0.755
AB30	53.84	74.726	0.451	0.750
AB7	56.09	78.140	0.200	0.765
AB10	54.60	72.735	0.408	0.750
AB16	54.71	72.313	0.475	0.746
AB19	54.62	74.623	0.298	0.759
AB22	55.09	73.742	0.388	0.752
AB25	54.10	72.674	0.373	0.753
AB28	54.02	73.551	0.372	0.753

Table 2b. Primary Care Training psychosocial evaluation survey table of factor analysis (obtained in SPSS using factor analysis method).

	Rotated Component Matrix(a)		
	Component		
	1	2	3
AB30B	0.769		
AB29B	0.736		
AB2B	0.658		
AB5B	0.616		
AB23B	0.612		
AB28B(A)	0.576		
AB27C		0.713	
AB15C		0.664	
AB18C		0.636	
AB20C		0.630	
AB21C		0.440	
AB19A			0.610
AB22A			0.580
AB7A			0.580
AB16A			0.540
AB25A			0.472
AB10A			0.407

Extraction Method: Principal Component Analysis.
Rotation Method: Quartimax with Kaiser Normalization.
a Rotation converged in 4 iterations.

(A=attitude sentence, figures are numbers of the questions, B=before the training and letters are the factors that attitude sentences belong to)

Table 2c. Psychosocial evaluating scale of family practice adaptation training.

A-	**ADAPTATION TO THE PROGRAM**
7-	There are questions in my mind related to the process N
10-	I do not understand what Family Practice is N
16-	The Family Practice system is quite appropriate for me
19-	The Family Practice system confused me N
22-	I have no problems about the process
25-	The success of the system depends on us
B-	**OCCUPATIONAL SELF-CONFIDENCE**
2-	I feel qualified to handle all kinds of health problems
5-	I can monitor chronic diseases like Diabetes Mellitus and Hypertension
30-	I can perform the treatment and follow- up of the people who will be my patients completely
23-	I know how to use every kind of individual preventive medicine
29-	I can give full information to the patients about their illnesses
28-	I know how to approach the people that are engaged with me
C-	**NON-EXHAUSTION**
15-	I don't think I can change the things that go wrong in my professional life N
18-	I feel that I have lost my ideals in my professional life N
21-	I have good ideals related to my professional life
27-	I feel that my energy for work is decreasing N
20-	I try to avoid the problems at the office N

Note: Calculate by subtracting the score of the questions having an N at the end from 6

Table 3. Demographic data of the physicians participating in the survey.

Gender		Age	Years in Profession
MALE	Number	271	271
	Median	43.5 ± 8	18.7 ± 8.3
	Minimum	24	1
	Maximum	72	56
FEMALE	Number	171	171
	Median	39.2 ± 7	14.9 ± 7
	Minimum	24	1
	Maximum	60	33

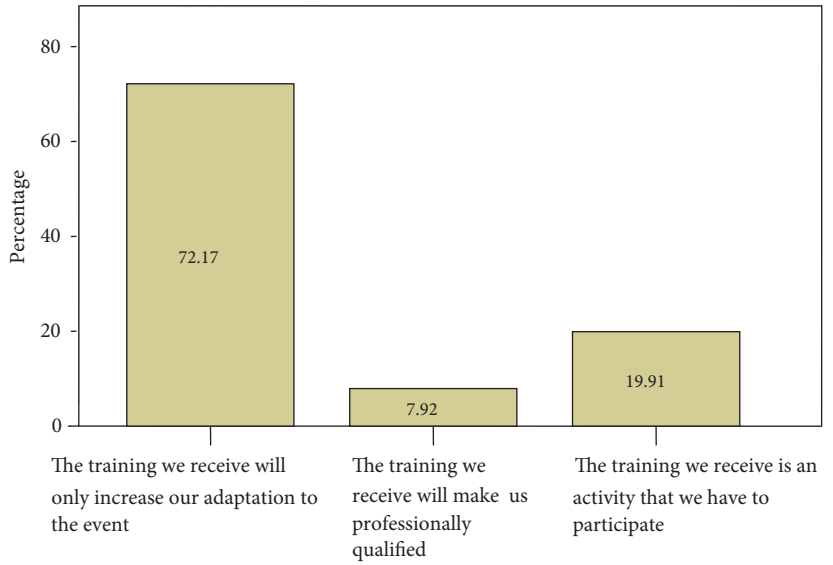

Figure 1. A view into Training.

While 38% of the participants considered family practice as a specialty, the majority (61.99%) stated that family practice was the name of a system (Figure 2). With respect to views on the family practice system, while the majority of the participants (79.8%) were of the opinion that family practice would be a better system, it was not thought to be a good system by 20% of the participants (Figure 3).

With respect to the first phase training, while the majority of the participants (64.6%) indicated that specialty training would also be required in future, 35.3% thought that the training they received was sufficient (Figure 4).

Average scores of non-exhaustion, professional self-confidence, and adaptation to the program for every participant were calculated (Table 4). Although average scores for the 3 factors after the training were higher than averages for pre-training generally, only the professional-self confidence factor scores were statistically significant ($P < 0.001$).

Correlations between factor scores, ages of the participants, and their years of experience were

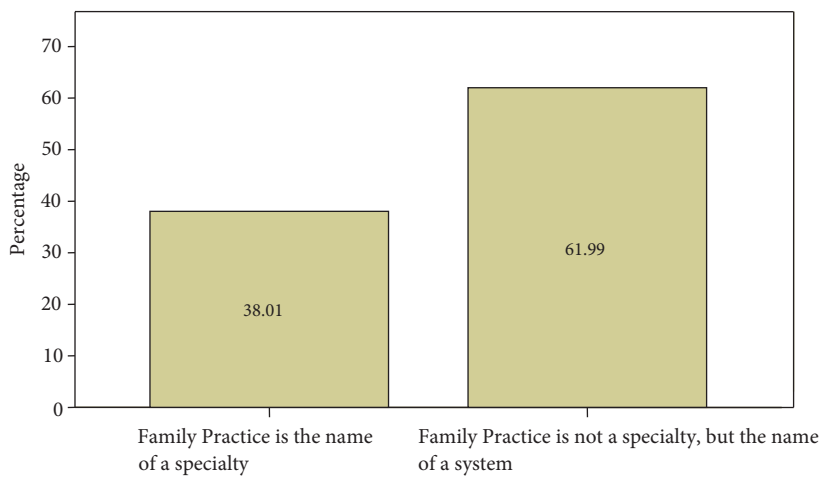

Figure 2. Information on family practice.

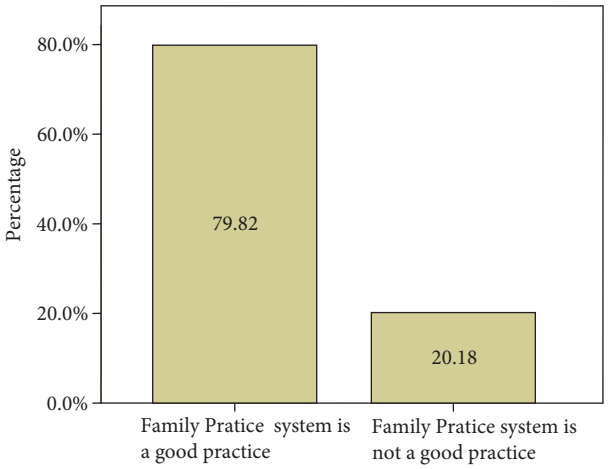

Figure 3. A view into family practice system.

Figure 4. Thoughts about specialty in the future.

Table 4. Comparison of factor scores during pre- and post-training period.

		AP_PRE	AP_POST	OSC_PRE	OSC_POST	NE_PRE	NE_POST
N	Valid	442	442	442	442	442	442
Mean		3.23	3.24	3.76	4.06	2.89	2.90
Median		3.16	3.16	3.83	4.00	2.80	2.80
Std. Deviation		0.475	0.649	0.700	0.907	0.662	0.910
Minimum		1.17	1.83	1.67	2.00	1.40	1.40
Maximum		4.50	10.50	5.00	12.00	6.00	12.80
Percentiles	10	2.66	2.66	2.83	3.16	2.00	2.00
	20	2.83	2.83	3.16	3.50	2.40	2.40
	30	3.00	3.00	3.50	3.66	2.40	2.40
	40	3.16	3.16	3.66	3.83	2.60	2.60
	50	3.16	3.16	3.83	4.00	2.80	2.80
	60	3.33	3.33	4.00	4.16	3.00	3.00
	70	3.50	3.50	4.16	4.50	3.20	3.20
	80	3.66	3.66	4.50	4.66	3.40	3.40
	90	3.83	3.83	4.66	4.83	3.80	3.80

AP_PRE =Adaptation of Program Factor, Pre-training, AP_POST =Adaptation of Program Factor, Post-training
OSC_PRE = Occupational Self-Confidence Factor, Pre-training, OSC_POST = Occupational Self-Confidence Factor, Post-training
NE_PRE = Non-Exhaustion Factor, Pre-training, NE_POST = Non-Exhaustion Factor, Post-training

examined. There were positive correlations between occupational experience and adaptation to the program, between age and occupational years, as well as professional self-confidence (post-training) and adaptation to the program (Table 5). In addition, positive correlations between non-exhaustion and occupational self-confidence, and non-exhaustion and adaptation to the program were found. Also, there were positive correlations between occupational self-confidence and adaptation to the program.

Table 5. Correlations of various parameters with each other.

		Age	Years in profession	Non-exhaustion (Before T.)	Non-exhaustion (After T.)	Occupational self-confidence (Before T.)	Occupational self-confidence (After T.)	Adaptation to the program (Before T.)	Adaptation to the program (After T.)
Age	R A	1.000	0.935(**)	0.007	-0.045	0.092	0.098(*)	0.132(**)	0.132(**)
	p	.	< 0.001	0.888	0.344	0.053	0.039	0.006	0.005
	Number	442	442	442	442	442	442	442	442
Years i profession	R	0.935(**)	1.000	0.014	-0.052	0.081	0.071	0.130(**)	0.111(*)
	p	< 0.001	.	0.763	0.276	0.091	0.134	0.006	0.020
	Number	442	442	442	442	442	442	442	442
Non-exhaustion (Before T.)	R	0.007	0.014	1.000	0.575(**)	0.172(**)	0.212(**)	0.419(**)	0.245(**)
	p	0.888	0.763	.	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
	Number	442	442	442	442	442	442	442	442
Non-exhaustion (After T.)	R	-0.045	-0.052	0.575(**)	1.000	0.249(**)	0.402(**)	0.341(**)	0.524(**)
	p	0.344	0.276	< 0.001	.	< 0.001	< 0.001	< 0.001	< 0.001
	Number	442	442	442	442	442	442	442	442
Professional self-confidence (Before T.)	R	0.092	0.081	0.172(**)	0.249(**)	1.000	0.638(**)	0.371(**)	0.247(**)
	p	0.053	0.091	< 0.001	< 0.001	.	< 0.001	< 0.001	< 0.001
	Number	442	442	442	442	442	442	442	442
Professional self-confidence (After T.)	R	0.098(*)	0.071	0.212(**)	0.402(**)	0.638(**)	1.000	0.294(**)	0.447(**)
	p	0.039	0.134	< 0.001	< 0.001	< 0.001	.	< 0.001	< 0.001
	Number	442	442	442	442	442	442	442	442
Adaptation to the program (Before T.)	R	0.132(**)	0.130(**)	0.419(**)	0.341(**)	0.371(**)	0.294(**)	1.000	0.484(**)
	p	0.006	0.006	< 0.001	< 0.001	< 0.001	< 0.001	.	< 0.001
	Number	442	442	442	442	442	442	442	442
Adaptation to the program (After T.)	R	0.132(**)	0.111(*)	0.245(**)	0.524(**)	0.247(**)	0.447(**)	0.484(**)	1.000
	p	0.005	0.020	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	.
	Number	442	442	442	442	442	442	442	442

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

A Correlation coefficient (Spearman's rho)

Discussion

The majority of the participants held the view (72%) that the training would enhance their adaptation. This was a realistic expectation, and compatible with the purpose of the training. Besides, approximately 8% of them thought that this training would increase their professional qualifications. It was observed that 35.3% of the participants thought that the training they received was sufficient and there was no need for specialised training. Training can provide a realistic result, but this is only possible with realistic expectations. Being a short-term adaptation training, which aimed to introduce the new work definitions and applications, it was seen that the perceptions of some attendees did not accurately reflect the reality. When considering the mission given to family medicine practitioners, it must be foreseen that, following a positive change happening in the transition period, there will also be a need for ongoing training. The expected second and subsequent phases of training can be supposed to lead towards this goal. In the specialised training part of the same field, particular vested interests provided in for certain regulations came into question; not only theoretical, but also practical training to consolidate working methods. Therefore, prevention of the confusion of the concepts and determining the boundaries are quite important for the success of the event, future planning, and legal aspects.

While most of the participants (62%) stated that Family Practice was the name of a system, a small percentage perceived it as a specialty. At this point, a conflict of definition became clear. In the definition made by the World Family Doctors (WONCA) Region Europe in 2002, Family Practice contains training special to itself and primary health care practitioners need the training. According to this definition, Family Medicine/General Practice is an academic and scientific discipline, with its own education/training content, investigations, evidence base, and clinical applications (9). The goal of the European Medical Specialists' Union (UEMS) is to become the only authority in post-graduate training in this field.

Most of the participants (64.6%) believed that specialised training was necessary after the training they had received. Their opinions on this subject were similar to the ones who suggested that "Family Practice" should be defined as a specialism years ago. This result may be considered normal, bearing in mind the fact that these primary care workers' mission adds a big burden to them and carries significant responsibility. The physicians who work in the primary care sector should have specific post-graduate training in this field. In our country, the physicians who receive this training are "Family Medicine Specialists." Currently, the number of family medicine specialists is not sufficient to meet the needs of the country; therefore, there is a need to train general practitioners in order to perform these duties. This training should be given in a relatively limited transition period and should not be seen as an alternative to specialised training. After the transition period, new graduates of medical faculties should be obliged to receive specialised family practice training in order in primary care (10).

The Turkish Association of Family Physicians (TAHUD) concluded that "When the transition process is over, all practitioners should be obliged to receive family practice specialised training in order to work in primary care" (11). However, in order to provide the expected high performance, practitioners with real specialised training are needed in this field. In any case, at this time, the minimum requirements for becoming a specialist are in place. When we consider the 6 years duration of specialised training in Japan for example, the need to make improvements in the quality and duration of this training is better understood. Also, the content of the specialised training should be considered. There should be theoretical education compatible with valid guidelines, sufficient clinical practice, and their consolidation. Legal, ethical, and human aspects should also be considered in specialised training. In Turkey, in order to get this training in other medical specialisms, general practitioners should pass a postgraduate exam. Those practitioners who succeed in this exam after going through so many difficulties earn the qualifications and legal rights of a medical specialism. For example, no one can get specialised training or become a specialist via alternative methods (e.g. education via the internet), even in areas of need, without entering that exam and without fulfilling certain conditions. This is the legal aspect of the training. Thousands of family medicine

specialists who have successfully completed this training by complying with legal requirements work in our country and continue to provide service to society. Their vested rights are in question. There are both human and legal aspects involved here.

Primary care training in the transition period includes short-term adaptation training programme to introduce new work definitions and applications to be implemented along with transferring rights and responsibilities. In the factor scores of the survey given to the participants, it is seen that post-training "Occupational Self-confidence" increased following the training. Therefore, applied training increases occupational self-confidence of the participants, which is quite satisfactory.

In multifactorial analyses, the correlation between the age and occupational self-confidence and adaptation to the program scores, and also the correlation between the professional experience and adaptation to the program scores showed the importance of occupational experience. This demonstrates what can be gained through putting professional practice alongside professional knowledge. With increasing occupational self-confidence and adaptation to the program, non-exhaustion increases, too (exhaustion decreases). Therefore, professional service training programs bring professional efficacy and psychosocial progress at the same time.

Conclusion

Adaptation training in a family medicine practice provides a positive beginning and psychosocial improvement to practitioners in primary care. These factors should be researched through comprehensive studies in the near future, too. Our scale which underwent validity and reliability analysis may be used for these future evaluations. However, for the long-term success of the system, it should be known that these types of training are not sufficient and the specialised training should be improved both qualitatively and quantitatively in accordance with the rules and regulations of the specialism. While this training is pending, the concepts should be reviewed and the legal, ethical, and human aspects of this should not be ignored.

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