

## Family Physicians' Competency and Satisfaction about Emergency Services in Family Practice Centers, Egypt

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### Abstract:

**Background:** Emergency situations are not out of the ordinary in an active family practice. Actually, 90% of the cases seen in emergency room can be handled perfectly by a qualified family physician. **Objectives:** This study aimed to evaluate Family physicians' perceived competency in emergency skills and satisfaction on emergency services in family practice centers. **Methods:** This study is a cross-sectional analytic study; it was conducted between January and November 2017, in family medicine department. All family postgraduate physicians (master or medical doctorate) in the study period were included. Sample recruited was 35 family physicians. Data were collected using a self-administered questionnaire to determine the physicians' perceived competency and satisfaction on dealing with emergency cases. **Results:** Physicians' age mean (SD) was 31.7 (4.7) years, most of them were females (85.7%), only 8.6% were qualified with master degree. Half (51.4%) did not attend Basic life support course. Also 80.0% and 77.1% did not attend Advanced Cardiac Life Support or Advanced Trauma Life Support course respectively. Males reported higher level of competency (mean rank=27.30),  $p=0.028$ . Physicians who had master degree reported higher competency in performing emergency skills (mean rank=32.83),  $P=0.009$ . Physicians who had attended ACLS (<1 year) reported highest score of perceived level of competency in performing skills (mean rank=31.0),  $P=0.015$ . **Conclusion:** There are deficits in perceived competency in performing emergency skills among family physicians, and high dissatisfaction with current emergency services. Also there is need for more training courses as BLS, ACLS, and ATLS for family physicians.

**Keywords:** Emergency care, PHC, Satisfaction, Training, Competency.

**Introduction:** Primary health care centers provide care to an expansive number of medically underserved Egyptians. Primary health care (PHC) is defined by the World Health Organization (WHO) as essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost the community and the country can afford. Primary Health Care (PHC) encompasses services as ; family planning, maternity care, child care, dental care, health educational services, communicable diseases control, emergency care and environmental health services.<sup>(1)</sup> Since 1997, Health Sector Reform Program was the main concern of the Ministry of Health and Population(MOHP) in Egypt.

The issue of "quality" figures into all three components of the reform program strategy. 1. implementing an integrated family practice care model; 2.developing a new social insurance financing mechanism through the establishment of a Family Health Fund (FHF); and 3) strengthening the role of the Ministry of Health

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and Population in a line with a facility accreditation program. It nullified its previous wellbeing offices maternal and child health centers and dispensaries and **combined** these services into PHC centers (PHCCs), which provide both curative and preventive aspect.<sup>(2)</sup> Primary healthcare centers (PHCCs) as often as possible are reached for emergency reasons and are relied upon to give basic and advanced life support during emergency circumstances.<sup>(3)</sup>

An emergency in the workplace setting can be tricky without satisfactory staff, support, tools, and protocols. In spite of the fact that numerous emergencies are not immediately life threatening, one risks the 'worst case scenario' happening if not sufficiently arranged.<sup>(4)</sup> Several studies have demonstrated that emergency situations are not out of the ordinary in an active family practice/primary health care office.<sup>(3-4)</sup> An emergency is “a sudden incident that necessitates urgent and appropriate management to treat its outcomes and evade its sequelae”.<sup>(5)</sup>

Strengthening family practice centers to cover emergency public health needs can be made by applying the “revitalization of PHC approach” through (1) universal coverage, and equity; (2) participation of the community; (3) inter-sectoral collaboration; and (4) appropriate use of technology.<sup>(6)</sup> Recent studies estimated some of factors that affect the provision of high quality emergency services at the primary care level. These are; good governance and collaboration among other health sector partners, sufficient health sector financing which would in turn result in adequate health infrastructure, availability of equipment, basic medicines and motivated efficient services.<sup>(7-8)</sup>

Some of the emergencies can be managed completely at a family practice while others should be referred to hospital after initial management. The degree to which a patient ought to be overseen might be controlled by the level of seriousness of the condition, experience of the doctor and distance to the nearest hospital.<sup>(9)</sup> Otherwise, absence of proper referral at PHC level could be the reason for health risk and imminent danger to life. The triage system must be adjusted to allow channeling of PHC patients to the appropriate level of care. It would be useful to create a standard letter that can be used when referring a patient to the appropriate level of care.<sup>(10)</sup>

Emergency medicine lies in the field of practice of family medicine because it is the integral part of all the medical, surgical, psychiatric, pediatric and other specialties. Emergency medicine is not, properly speaking, a discipline in its own

right. In order to clarify its contents, we must dip into each and all of the known medical specialties, as well as into family medicine, which already unifies them all.<sup>(11)</sup>

Actually, 90% of the cases seen in emergency room can be handled perfectly by a well-trained qualified family physician using a well-organized training program including basic life support (BLS), Advanced Trauma Life support (ATLS), Advanced Cardiac Life support (ACLS) and so on.<sup>(11)</sup> Data regarding Family physicians' satisfaction about emergency services, competency, and training in emergency skills in family practice centers, Suez Canal University, Egypt aren't available. Relevant information from health service providers, especially family physicians training and acquired skills, are very important to health care policy-makers for improvement quality of patient care and providing effective and optimal management of the current services.

This study aimed to evaluate Family physicians' perceived competency regarding emergency skills and satisfaction about emergency services at the level of family practice centers.

#### **Methods:**

This study is a cross-sectional analytic study, it was conducted between January and November 2017, in the family medicine department; faculty of medicine; Suez Canal University in Ismailia city, Egypt. Target population: all family physicians in postgraduate studies of master or medical doctorate degrees during the study period, in the family medicine department, faculty of medicine, Suez Canal University, who fulfilled the inclusion criteria (work as family physician and recruited in postgraduate studies of family medicine) and agreed to take part in the study, we recruited them. Those who refused to **participate** in the study, not family physician, or not recruited to postgraduate studies were excluded from the study.

The study group was participated in the study; sample recruited all postgraduate family physicians (35 Physicians), data were collected during the scientific day of master and medical doctorate in the family medicine department by convenience sampling. Family physicians are working in nine family practice centers, which affiliated to Family medicine department, which are distributed in three geographical sectors. There are three centers in Ismailia city, two centers in Port Saied city and four centers in Suez city.

### **Tools of the study:**

The invited physicians filled a self-administered questionnaire which consisted of three parts:

Part (1): It contained personal data about physicians: age, gender, and qualification degree. Part (2): It was training level, previous experience, and courses. Part (3): It formed of three sections: A- perceived level of competence in performing emergency skills (12 skills), with scoring system from 1-4. 1= I don't know where to start skills (fail to start), 2= I will do only if no one else is available (acceptable), 3= I will attempt in most cases (very good), and 4= I will attempt in all cases (excellent). B- How many emergency cases seen in last 12 months (12 conditions): zero, 1-2, and 3 or more cases.

C- Satisfaction of the PHC physicians with the emergency services provided at PHC center (12 conditions) with scoring on likert scale from 1 to 5.

The scale 1: means I am satisfied with the facilities, equipment, trained health care personnel and medications available to deal with such cases (totally satisfied). 2: means I am satisfied with the facilities, equipment and medications but we need more training for health care personnel (physicians and nurses) when dealing with such cases (unsatisfied with training). 3: means I am satisfied with the facilities, equipment and trained health care personnel but medications are deficient when dealing with such cases (unsatisfied with medication). 4: means I am satisfied with the medications and trained personnel but facilities and equipment are deficient when dealing with such cases (unsatisfied with equipment and facilities). Finally; 5: means I am overall unsatisfied about the services provided at our PHC center when dealing with such cases (totally unsatisfied). The questionnaire faced validity in previous research at Jeddah, Saudi Arabia, with acceptable reliability<sup>(12)</sup>.

### **Ethical considerations:**

Informed consent was obtained from the participants after explaining the objectives of the research. The questionnaires were anonymous but had code numbers. Confidentiality of data was maintained and the physicians were free to accept or not to participate in the research.

### **Statistical methods:**

The collected data were analyzed using Statistical Package for Social Sciences (SPSS 24.0). Descriptive statistics: qualitative data were presented in frequencies and percentages and quantitative data were presented in median (interquartile range),

mean (SD), and mean ranks. Data were tested for normality using Shapiro Wilk test, and suitable non-parametric tests (Mann Whitney test and Kruskal Wallis tests) were used to test the relationship between physicians' factors with perceived level of competency in emergency skills. Tests were two tailed and P value was considered significant if  $<0.05$ .

### **Results:**

This study was conducted on 35 family physicians, working in family practice centers, the physicians' age ranged from 25-46 years, median (IQR) was 31(28-35) years; most of them were females (85.7%), and only 8.6 % qualified with master degree. About training in emergency 51.4% of them did not attend basic life support course, while 80.0% and 77.1% did not attend ACLS or ATLS course respectively. Majority of the sample have experience in emergency services (74.3%), and 51.4 % worked for more than 5 years in primary health care (Table - 1).

Table (2) shows perceived level of competency in performing emergency skills, regarding cardiac compression and mouth-to- mouth resuscitation about half (45.7 %) will do it only if no one else is available, while bag and mask resuscitation, and inserting IV cannula only 37.1 % of physicians will do if no one else is available. Most of the sample 74.3% and 82.9% do not know where to start regarding intubation or defibrillation respectively. About one third (34.3%) of the sample will attempt reading ECG, nebulizing or oxygen therapy in most cases. Also 34.3% of the sample will attempt simple suture in all cases. About half of participants (54.3, and 48.6%) don't know where to start regarding naso-gastric tube or urinary catheter insertion. Finally; 37.1% of physicians will attempt to use IV fluids and medications in most of cases (Table - 2).

Table (3) shows the prevalence of emergency cases seen in last 12 months; about 60% of physicians had seen 3 or more cases of acute asthma, while only 20% of physicians had seen 3 or more cases of myocardial infarction. More than one third of the sample (40%) has seen 1 or 2 cases of angina, while majority of them (80%) have not seen cardiac arrest, about more than half (60%) have not seen severe dehydration, while 8.6% have seen 3 or more cases. About half of physicians (51.4%) have seen 3 or more cases of renal colic, while 51.4% have not seen a case of acute GIT bleeding. About 42.9% of physicians have seen 1 or 2 cases of hypoglycemia, while 14.3% of them have seen 3 or more cases of diabetic ketoacidosis. About two thirds 68.6%

didn't see a case of convulsions, and 71.4 didn't see a case of anaphylaxis; however 48.6 % of physicians have seen 3 or more cases of vaginal bleeding.

**Table** (4) shows the highest rate of satisfaction with all emergency services provided at family practice centers (facilities, equipment, trained personnel and medications) as reported in dealing with hypoglycemia cases by third of physicians (28.6%), followed by renal colic by one quarter of physicians (25.7%) then acute vaginal bleeding by (20.0%) of physicians, whereas the lowest rates were reported in dealing with cases of cardiac arrest and diabetic ketoacidosis in (2.9%) of study sample.

Regarding acute GIT bleeding, anaphylaxis, or convulsions only (5.7%) of physicians were satisfied, about severe dehydration only (8.6%) of physicians were satisfied, acute asthma and angina pectoris (11.4%), while myocardial infarction service satisfied only (14.3%). On contrary, the highest rate of dissatisfaction with all emergency services provided at centers were reported in dealing with cardiac arrest (77.1%), followed by acute GIT bleeding (51.4%), then myocardial infarction, angina, severe dehydration, and anaphylaxis (40.0%).

Dissatisfaction with trained personnel (physicians and nurses), the highest rates reported in dealing with cases of acute asthma (42.9%), convulsions (31.4%), renal colic, and acute vaginal bleeding (28.6%), severe dehydration (25.7%), followed by angina, and hypoglycemia (20.0%). Dissatisfaction with availability of medications, the highest rates were reported in cases of acute asthma (25.7%), renal colic, hypoglycemia, and anaphylaxis (22.9%), then angina 20.0%, myocardial infarction, diabetic ketoacidosis, and convulsions (17.1%). Concerning the dissatisfaction with facilities and equipment, the highest rates were reported in cases of diabetic ketoacidosis (28.6%), convulsions (20%), acute GIT or vaginal bleeding (17.1%).

Table (5) shows that males reported higher score of perceived level of competence in performing emergency skills scale (mean rank=27.30), than females (mean rank=16.45), and the difference was statistically significant,  $p=0.028$ . Physicians hold a master degree reported higher score of perceived level of competence in performing emergency skills scale (mean rank=32.83) whereas those with Medical bachelors and bachelors of surgery (MBBS) reported lower score (mean rank=16.61), and the difference was statistically significant,  $P=0.009$ . Physicians attended ACLS (<1 year) reported highest score of perceived level of competence in performing emergency skills scale (mean rank=31.0), followed by 1-2 years (mean

rank=28.0), then >2 years (mean rank=27.0), and finally who not attend at all (mean rank=16.0), and the difference was statistically significant, P=0.015.

### **Discussion:**

This study showed deficits in training of emergency skills to family physicians, as only 48.6% attended basic life support course, from them 5.7% attended in less than 1 year, while 80.0% and 77.1% did not attend ACLS or ATLS course respectively. Only 5.7% and 8.6% attended ACLS and ATLS respectively in last year. In contrary another study in Saudi Arabia, authors reported that primary health care physicians who attended basic life support (BLS) courses (97.1%) which is higher than our study may be due to the cost of the courses and deficits of workshops in this domain. Similarly (83.5%) had not attended ATLS courses, with 60.7% never attending ACLS course relatively similar to this study. It might be attended by specialists of emergency department and other specialties other than family medicine.<sup>(12)</sup> Also, 46.1% attended BLS in the last year, whereas 6.8% and 5.3% had attended ACLS and ATLS last year, respectively, which is similar to this study.<sup>(12)</sup> So, there is deficit in training area of emergency and there is a need for training.

Majority of the sample have experience in emergency services (74.3%), similarly in another study 72.3% of physicians had previous experience in hospitals emergency departments.<sup>(12)</sup> This could be explained by exposure to emergency cases in the year of training after graduation to all medical students, which plays an important role in their experience.

Another previous study in Egypt reported that 52.9% of physicians are in great need for knowledge in emergency care and 76.5% of physicians in high need for training in emergency care.<sup>(13)</sup> Regarding perceived level of competency in performing emergency skills less than one third of physicians will attempt to do skills in all emergency cases. In our study only 25.7% will perform nebulization and oxygen therapy in all cases, in contrary similar studies reported 50.5% will perform nebulization and oxygen therapy in all cases, while the study showed that 34.3% will perform simple suture in all cases, in contrary 44.2% will perform simple suture in all cases in comparable study. This could be explained by lack of training in these skills, besides deficiency of exposure to such cases.

Also 22.9% of physicians will attempt cardiac compression versus 38.8% in comparable study, bag and mask resuscitation only 20% of physicians will perform, versus 37.9% in comparable study, and physicians using intravenous (IV) fluid &

medications in 28.6% versus 36.4% in all cases. Also 31% will read ECG for all cases versus 67% in another study.<sup>(12)</sup> This could be explained by deficient training in these skills, besides **lack** of exposure to such cases, most of emergency cases go directly to hospital, instead of family practice centers **availability**.

However, another study in Egypt showed that only 5.9% of physicians felt that they were not competent to deal with emergency cases, and 76.5% were **more** competent, this may be due to general survey that was done regarding self-confidence not for each item as in this study.<sup>(13)</sup>

Regarding emergency cases seen in last 12 months, the most common cases were acute asthma, renal colic, and vaginal bleeding, **These results were similar to study in Saudi Arabia but fewer cases than our study.**<sup>(12)</sup> This could reflect nature of cases seen in emergency care in primary health care to be targeted in training courses.

The highest rate of satisfaction with all emergency services provided at family practice centers were reported in dealing with hypoglycemia, **followed by renal colic**. This could be explained by **feasibility and affordability of management of such health problems at the level of family practice. Also, the family physician can afford such service with the acquired skill during his/her training.** Acute vaginal bleeding came at a lower rank of satisfaction. It is a common practice and physicians are competent in **handling** it to a great extent. Training in women health is mandatory in postgraduate programs ( master and medical doctorate). The lowest rates **of satisfaction** were reported in dealing with cases of cardiac arrest and diabetic ketoacidosis, acute GIT bleeding, anaphylaxis, convulsions, severe dehydration, acute asthma and angina pectoris, and myocardial infarction. In another study, satisfaction was higher than our study especially in cases of acute asthma, renal colic, and severe dehydration.<sup>(12)</sup> This reflects deficiency in training of physicians on guidelines, deficiency of instruments, and drugs which needed in emergency cases to improve satisfaction of physicians regarding emergency services. This may be lower socioeconomic status in Egypt and cost of these services that make them not available in centers, so physicians are unsatisfied.

In a comparable study acute asthma was the highest rate of satisfaction with all emergency services, followed by renal colic, and hypoglycemia<sup>(14)</sup> also due to few skills needed and availability of low cost treatment to these cases. Another study in Egypt about satisfaction of patients in emergency services, 35.7% was satisfied with the emergency services provided by the PHC facilities. However, 64.3% were

dissatisfied<sup>(13)</sup>, also due to scarce resources in primary health care and **lack** of training of PHC physicians as most of them **un**qualified by postgraduate studies or courses, as most of them newly graduated doctors without previous experience.

In this study; males reported higher score of perceived level of competency in performing emergency skills scale; it was insignificant in another study,<sup>(12)</sup> this may be due to more interest of males in emergency training and practicing more than females. Physicians **hold a** master degree reported higher score of perceived level of competency, similar to another study showed that qualification is related to perceived competency.<sup>(12)</sup> Physicians who had attended ACLS (<1 year) reported highest score of perceived level of competency in performing emergency skills, in another study it is not significant.<sup>(12)</sup> As it is easy to remember training if taken from less than one year, this reflects the importance of continues medical education and evaluation.

#### **Study limitations:**

Limitations of the study were in the form of small sample, sampling technique which is convenience without randomization, and **scarcity** of comparable studies.

#### **Conclusions:**

There is a deficit in perceived competency in performing emergency skills among family physicians, and high dissatisfaction with current emergency services due to **lack of** training, scarce resources as instruments and drugs in family practice centers. There is need for more training courses as BLS, ACLS, and ATLS for family physicians.

#### **Conflict of Interest:**

There is no conflict of interest.

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**Table (1): Personal characteristics, training and previous experience of the study sample (n=35)**

Physicians' factors	Frequency	%
Age (Years)		
▪ 20- <30	12	34.3
▪ 30- <40	22	62.9
▪ 40-	1	2.9
Mean (SD)	31.7 (4.7)	
Gender		
▪ Male	5	14.3
▪ Female	30	85.7
Qualification		
▪ MBBS <sup>1</sup> (in master)	32	91.4
▪ Master degree (in MD)	3	8.6
BLS <sup>2</sup>		
▪ <1 year	2	5.7
▪ 1-2 years	1	2.9
▪ >2 years	14	40.0
▪ Don't attend at all	18	51.4
ACLS <sup>3</sup>		
▪ <1 year	1	5.7
▪ 1-2 years	2	2.9
▪ >2 years	4	11.4
▪ Don't attend at all	28	80.0
ATLS <sup>4</sup>		
▪ <1 year	3	8.6
▪ 1-2 years	2	5.7
▪ >2 years	3	8.6
▪ Don't attend at all	27	77.1
Experience		
▪ Yes	26	74.3
▪ No	9	25.7
Years of working in PHC <sup>5</sup>		
▪ < 1 year	3	8.6
▪ 1-5 years	14	40
▪ >5 years	18	51.4

<sup>1</sup> Bachelor of Medicine/ Bachelor of Surgery <sup>2</sup> Basic Life Support <sup>3</sup> Advanced Cardiac Life Support <sup>4</sup> Advanced Trauma Life Support <sup>5</sup> Primary Health Care. MD: Medical Doctorate

**Table (2): Perceived level of competency in performing skills (n=35)**

Skills	Fail to start		Acceptable		Very good		excellent	
	N	%	N	%	N	%	N	%
▪ Cardiac compression	5	14.3	16	45.7	6	17.1	8	22.9
▪ Mouth to mouth resuscitation	8	22.9	16	45.7	5	14.3	6	17.1
▪ Bag and Mask Resuscitation	10	28.6	13	37.1	5	14.3	7	20.0
▪ Inserting IV cannula	5	14.3	13	37.1	13	37.1	4	11.4
▪ Intubation	26	74.3	7	20.0	1	2.9	1	2.9
▪ Defibrillation	29	82.9	5	14.3	0	0	1	2.9
▪ Reading ECG*	2	5.7	10	28.6	12	34.3	11	31.4
▪ Nebulization and Oxygen Therapy	5	14.3	9	25.7	12	34.3	9	25.7
▪ Simple Suture	5	14.3	8	22.9	10	28.6	12	34.3
▪ NGT** Insertion	19	54.3	8	22.9	6	17.1	2	5.7
▪ Urinary Catheter insertion	17	48.6	12	34.3	2	5.7	4	11.4
▪ Using IV Fluids and medications	7	20.0	5	14.3	13	37.1	10	28.6

\*Electrocardiogram

\*\*Naso-gastric Tube

**Table (3): Cases seen in last 12 months by study sample (n=35)**

Type of emergency case	0		1-2		≥ 3	
	N	%	N	%	N	%
▪ Acute asthma	3	8.6	11	31.4	21	60.0
▪ Myocardial infarction	14	40.0	14	40.0	7	20.0
▪ Angina pectoris	13	37.1	14	40.0	8	22.9
▪ Cardiac arrest	28	80.0	4	11.4	3	8.6
▪ Severe dehydration	21	60.0	11	31.4	3	8.6
▪ Renal colic	2	5.7	15	42.9	18	51.4
▪ Acute GIT Bleeding	18	51.4	15	42.9	2	5.7
▪ Hypoglycemia	11	31.4	15	42.9	9	25.7
▪ Diabetic ketoacidosis	17	48.6	13	37.1	5	14.3
▪ Convulsions	24	68.6	10	28.6	1	2.9
▪ Anaphylaxis	25	71.4	9	25.7	1	2.9
▪ Acute vaginal bleeding	7	20.0	11	31.4	17	48.6

**Table (4): Satisfaction of family physicians with the emergency services provided at Family Practice centers (FPCs) (n=35)**

Emergency condition	Satisfaction with the emergency services provided at FPCs				
	Totally satisfied N (%)	Unsatisfied with training N (%)	Unsatisfied with medication N (%)	Unsatisfied with equipment and facilities N (%)	Totally unsatisfied N (%)
▪ Acute asthma	4 (11.4)	15 (42.9)	9 (25.7)	2 (5.7)	5 (14.3)
▪ Myocardial infarction	5 (14.3)	6 (17.1)	6 (17.1)	4 (11.4)	14 (40.0)
▪ Angina pectoris	4 (11.4)	7 (20.0)	7 (20.0)	3 (8.6)	14 (40.0)
▪ Cardiac arrest	1 (2.9)	2 (5.7)	3 (8.6)	2(5.7)	27 (77.1)
▪ Severe dehydration	3 (8.6)	9 (25.7)	4(11.4)	5 (14.3)	14 (40.0)
▪ Renal colic	9 (25.7)	10 (28.6)	8(22.9)	5 (14.3)	3 (8.6)
▪ Acute GIT Bleeding	2 (5.7)	5 (14.3)	4 (11.4)	6 (17.1)	18 (51.4)
▪ Hypoglycemia	10 (28.6)	7(20.0)	8 (22.9)	3 (8.6)	7 (20.0)
▪ DKA	1 (2.9)	6 (17.1)	6 (17.1)	10 (28.6)	12 (34.3)
▪ Convulsions	2 (5.7)	11 (31.4)	6 (17.1)	7 (20.0)	9 (25.7)
▪ Anaphylaxis	2 (5.7)	6 (17.1)	8(22.9)	5 (14.3)	14 (40.0)
▪ Acute vaginal bleeding	7 (20.0)	10 (28.6)	4 (11.4)	6 (17.1)	8 (22.9)

**Table (5): Relation between physicians' factors and perceived level of competency of skills (score 12-48)**

Physicians factors	Median (IQR)	Mean rank	P value
Age (Years)			
▪ < 30	27 (23.0-34.5)	19.25	0.601*
▪ 30 -	27 (19.0-33.0)	17.35	
Gender			
▪ Male	34 (27.5-41.0)	27.30	.028*
▪ Female	23.5 (19.75-32.25)	16.45	
Qualification			
▪ MBBS <sup>1</sup>	25.5 (20.0-31.50)	16.61	.009*
▪ Master degree	37.0 (36.0-42.0)	32.83	
BLS <sup>2</sup>			
▪ <1 year	32.0 (28.0-36.0)	26.0	0.065**
▪ 1-2 years	35.0 (35.0-35.0)	29.5	
▪ >2 years	29.5 (23.0-34.75)	21.50	
▪ Don't attend at all	22.5 (19.0-27.75)	13.75	
ACLS <sup>3</sup>			
▪ <1 year	36.0 (36.0-36.0)	31.0	0.015**
▪ 1-2 years	34.0 (33.0-35.0)	28.0	
▪ >2 years	33.0 (27.5-40.75)	27.0	
▪ Don't attend at all	23.0 (19.25-30.0)	15.54	
ATLS <sup>4</sup>			
▪ <1 year	33.0 (28.0-36.0)	26.17	0.208**
▪ 1-2 years	29.0 (23.0-35.0)	21.50	
▪ >2 years	29.0 (27.0-42.0)	25.17	
▪ Don't attend at all	23.0 (19.0-32.0)	16.04	
Experience			
▪ Yes	27.0 (19.75-33.25)	17.42	.570*
▪ No	30.0(21.5-34.0)	19.67	
Years working in PHC <sup>5</sup>			
▪ < 1 year	29.0 (23.0-35.0)	21.67	0.655**
▪ 1-5 years	25.0 (18.5-33.5)	16.32	
▪ >5 years	27.0 (20.75-33.25)	18.69	

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\*\* kruskal Wallis

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## الملخص العربي

### كفاءة و رضا أطباء الأسرة عن خدمات الطوارئ في مراكز طب الأسرة – مصر

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**الخلفية:** تقدم مراكز الرعاية الصحية الأولية الرعاية لعدد كبير من المواطنين. وتعرف منظمة الصحة العالمية الرعاية الصحية الأولية بأنها الرعاية الصحية الأساسية التي يمكن الوصول إليها بسهولة للأفراد والأسر في المجتمع عن طريق وسائل مقبولة لهم من خلال مشاركتهم وبتكلفة يمكن للمجتمع المحلي والبلد أن تتحملها. إن الرعاية الصحية الأولية تشمل خدمات مثل تنظيم الأسرة ورعاية الأمومة ورعاية الطفل ورعاية الأسنان والخدمات التعليمية الصحية ومكافحة الأمراض المعدية وخدمات الرعاية الصحية في حالات الطوارئ والصحة البيئية. في الواقع إن نسبة 90% من حالات الطوارئ يمكن التعامل معها تماما من قبل أطباء الأسرة المؤهلين.

**الأهداف:** تهدف هذه الدراسة الى تقييم كفاءة أطباء الأسرة في مهارات الطوارئ ورضاهم عن خدمات الطوارئ في مراكز طب الأسرة. **المنهجية وطرق البحث:** كان عدد المشاركين في البحث 35 من اطباء الاسرة باستخدام استبيان شمل بعض العوامل في الاطباء كالعمر و التدريب على مهارات الطوارئ و كفاءه الاطباء في مهارات الطوارئ و رضاهم عن خدمات الطوارئ بالمراكز الطبية. **النتائج:** اظهرت الدراسة بان متوسط عمر الأطباء 31 سنة ومعظمهم من الإناث (85,7%) و 8,6 في المائة فقط حاصلين على درجة الماجستير. كما تبين أن 51,4% لم يحضروا دورة إنعاش الحياة الأساسية، في حين أن نسبة كبيرة لم يحضروا دورة الإنعاش المتقدمة و غيرها من الدورات المتقدمة في طب الطوارئ. و أوضحت النتائج أن الذكور يعطون مستوى أعلى من الكفاءة في المهارات، و تبين أيضاً من الدراسة أن الأطباء الذين حصلوا على درجة الماجستير عن كفاءة أعلى في أداء مهارات الطوارئ.

**الخلاصة:** خلصت الدراسة أن هناك نقص في كفاءة أداء مهارات الطوارئ لدى أطباء الأسرة، وعدم الرضا الشديد عن خدمات الطوارئ الحالية. أيضا هناك حاجة لمزيد من الدورات التدريبية المتقدمة في طب الطوارئ و توفير الادويه و المستلزمات بالمراكز.