TRIDESET GODINA SPECIJALIZACIJE IZ PORODIČNE MEDICINE U POLJSKOJ: STUDIJA SLUČAJA INSTITUCIONALIZACIJE, PRAKSE I PERCEPCIJE PACIJENATA U OKVIRU PRIMARNE ZDRAVSTVENE ZAŠTITE

PREGLEDNI RAD

REVIEW ARTICLE

THIRTY YEARS OF FAMILY MEDICINE SPECIALTY IN POLAND: A CASE STUDY OF ITS INSTITUTIONALIZATION, PRACTICE, AND PATIENT PERCEPTION WITHIN PRIMARY HEALTHCARE

Mateusz Guziak[1,2]

[1] Medicinski univerzitet u Gdanjsku, Fakultet zdravstvenih nauka sa Institutom za pomorsku i tropsku medicinu, Odeljenje za istraživanje kvaliteta života, Gdanjsk, Poljska

[2] Univerzitet u Beogradu, Medicinski fakultet, Laboratorija za jačanje kapaciteta i performansi zdravstvenog sistema i kadrova za zdravstvenu pravičnost, Beograd, Srbija

[1] *Medical University of Gdansk, Faculty of Health Sciences with the Institute of Maritime and Tropical Medicine, Division of Quality of Life Research, Gdansk, Poland*

[2] *University of Belgrade, Faculty of Medicine, Laboratory for Strengthening the Capacity and Performance of the Health System and Workforce for Health Equity, Belgrade, Serbia*

SAŽETAK

Uvod: Specijalizacija iz porodične medicine (PM) u Poljskoj uvedena je početkom 1990-ih godina kao deo širih reformi zdravstvenog sistema, usmerenih na restrukturiranje primarne zdravstvene zaštite (PZZ) i unapređenje dostupnosti, kontinuiteta i koordinacije nege. Uprkos trodecenijskom razvoju, PM se i dalje suočava sa sistemskim i profesionalnim izazovima unutar poljskog zdravstvenog sistema.

Cilj: Ova studija koristi pristup studije slučaja kako bi istražila evoluciju specijalizacije iz porodične medicine u Poljskoj, sa posebnim fokusom na njene institucionalne temelje, obrazovanje specijalista, ulogu u pružanju PZZ i zadovoljstvo pacijenata pruženim uslugama.

Metode: Korišćen je eksplanatorini tip studije slučaja, uz analizu programskih dokumenata, nastavnih planova i programa, recenzirane naučne literature i nacionalne statistike. Tematska analiza sprovedena je u skladu sa okvirom za evaluaciju studija slučaja u zdravstvenim sistemima.

Rezultati: Specijalizacija iz porodične medicine stekla je punu kliničku i akademsku legitimaciju u Poljskoj. Ipak, samo manjina lekara u PZZ ima formalnu obuku iz PM. Iako program postdiplomske edukacije ispunjava evropske standarde, nedostaju mu longitudinalna evaluacija i ujednačen kvalitet supervizije. Pacijenti generalno iskazuju visoko zadovoljstvo međuljudskim aspektima nege, ali PM ocenjuju niže od drugih specijalističkih grana u oblastima kao što su komunikacija, empatija i emocionalna podrška. Ova specijalizacija se takođe suočava sa poteškoćama u regrutaciji, pri čemu mnoga mesta na specijalizaciji ostaju upražnjena uprkos finansijskim podsticajima.

Zaključak: Specijalizacija iz porodične medicine u Poljskoj ostvarila je značajne strukturne pomake, ali je i dalje nedovoljno iskorišćena i potcenjena unutar sistema PZZ. Dalje reforme treba da se usredsrede na jačanje obrazovnih puteva, poboljšanje uslova rada i promenu javne percepcije. Unapređenje komunikacionih veština i povećanje vidljivosti porodičnih lekara moglo bi doprineti većem zadovoljstvu pacijenata i privlačnosti ove specijalizacije.

Ključne reči: porodična medicina, primarna zdravstvena zaštita, Poljska, medicinsko obrazovanje, zadovoljstvo pacijenata, postdiplomska edukacija, zdravstvene reforme

ABSTRACT

Background: Family medicine (FM) specialty in Poland was introduced in the early 1990s as part of broader health reforms aimed at restructuring primary healthcare (PHC) and improving access, continuity, and coordination of care. Despite three decades of development, FM continues to face systemic and professional challenges within the Polish healthcare system.

Objective: This study used a case study approach to explore the evolution of family medicine specialty in Poland, examining its institutional foundation, specialist training, its role in PHC delivery, and patient satisfaction with services.

Methods: An explanatory case study design was employed, drawing on policy documents, training curricula, peer-reviewed literature, and national statistics. Thematic analysis was guided by a framework for case study evaluation in healthcare systems.

Results: Family medicine specialty has gained full recognition as a clinical and academic specialty in Poland. However, only a minority of PHC physicians are formally trained in FM. While the postgraduate training program aligns with European standards, it lacks longitudinal assessment and consistent quality of supervision. Patients report generally high satisfaction with interpersonal aspects of care but rate family medicine lower than specialist services in areas such as communication, empathy, and emotional support. The specialty also faces recruitment difficulties, with many FM residency slots unfilled despite financial incentives.

Conclusion: Family medicine specialty in Poland has achieved significant structural milestones but remains underutilized and undervalued within the broader PHC system. Reforms should prioritize strengthening its educational pathways, improving working conditions, and addressing public perceptions. Enhancing communication skills and increasing the visibility of family physicians could improve both patient satisfaction and the attractiveness of the specialty.

Keywords: family medicine, primary healthcare, Poland, medical education, patient satisfaction, postgraduate training, healthcare reform

Autor za korespondenciju:
Mateusz Guziak
Institut za socijalnu medicinu, Medicinski fakultet, Univerzitet u Beogradu
Dr Subotića 15, 11000 Beograd, Srbija
Elektronska adresa: mateusz.guziak@gumed.edu.pl

Corresponding author:
Mateusz Guziak
Institute of Social Medicine, Faculty of Medicine, University of Belgrade
15 Dr Subotića Street, 11000 Belgrade, Serbia
E-mail: mateusz.guziak@gumed.edu.pl

Primljeno • *Received*: July 19, 2025; **Revidirano • *Revised*:** September 18, 2025; **Prihvaćeno • *Accepted*:** September 21, 2025; ***Online first*:** September 25, 2025

DOI: 10.5937/smclk6-60277

UVOD

Porodična medicina (PM) je posebna medicinska specijalnost koja pruža sveobuhvatnu i kontinuiranu zdravstvenu zaštitu pojedincima i porodicama, odgovarajući na različite nivoe potreba zdravstvenog sistema. Prema definiciji Svetske organizacije porodičnih lekara (WONCA), porodična medicina je „akademska i naučna disciplina sa sopstvenim obrazovnim sadržajem, istraživanjem, bazom dokaza i kliničkom aktivnošću, te klinička specijalnost usmerena na primarnu zdravstvenu zaštitu (PZZ)". Odgovara na rastuće potrebe za pružanjem nege prilikom prvog kontakta, upravljanjem hroničnim bolestima, preventivnim uslugama i koordinacijom sve složenijih procesa nege pacijenata [1].

Sa stanovišta klasifikacije zanimanja, Međunarodna standardna klasifikacija zanimanja (ISCO-08) identifikuje lekare opšte prakse, uključujući i porodične lekare, pod šifrom 2211. Ovi stručnjaci „dijagnostikuju, leče i sprečavaju bolesti, povrede i druga fizička i mentalna oštećenja kod ljudi primenom moderne medicine" i obično rade u okruženjima koja obezbeđuju kontinuitet i sveobuhvatnost nege [2]. Porodični lekari predstavljaju prvi kontakt pacijenata u sistemu zdravstvene zaštite, odgovorni su za ranu dijagnostiku i rešavanje nediferenciranih problema, kontinuitet nege, usmeravanje pacijenata ka drugim nivoima zdravstvene zaštite i pružanje usluga orijentisanih na pojedinca i zajednicu. Direktive Evropske unije, uključujući Direktivu 2005/36/EC i njenu izmenu i dopunu Direktivu 2013/55/EU, definišu standarde i zahteve za medicinsku specijalizaciju u oblasti porodične medicine [3,4]. Ovi zahtevi podrazumevaju najmanje tri godine strukturirane obuke (uključujući iskustvo u bolničkoj i ambulantnoj nezi) i sticanje ključnih kompetencija, kao što su samostalno donošenje kliničkih odluka, komunikacione veštine, interdisciplinarna saradnja i etička medicinska praksa. Evropski ogranak Svetske organizacije porodičnih lekara (WONCA Europe) navodi jedanaest ključnih karakteristika ove discipline, koje su sadržane u šest osnovnih kompetencija: upravljanju primarnom zdravstvenom zaštitom, nezi usmerenoj na pacijenta, specifičnoj veštini rešavanja problema, sveobuhvatnom pristupu, orijentisanosti ka zajednici i holističkom pogledu na pacijenta [1].

Dok je PM široko prihvaćena kao klinička specijalnost u većini evropskih zdravstvenih sistema, njena akademska osnova se razvijala neravnomernije u zemljama Centralne i Istočne Evrope (CEE). Akademska PM ne podrazumeva samo uključivanje ove discipline u nastavne planove i programe, već i njenu institucionalizaciju unutar univerzitetskih struktura, sprovođenje istraživanja i postojanje posvećenih naučnih organizacija [5,6]. Sa metodološkog stanovišta, PM zauzima jedinstvenu poziciju među medicinskim disciplinama. Ona integriše biomedi-

INTRODUCTION

Family medicine (FM) is a distinct medical specialty that provides comprehensive and continuous healthcare to individuals and families addressing multiple levels of health system needs. According to the definition developed by the World Organization of Family Doctors (WONCA), family medicine is "an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty oriented to primary care (PHC)". It responds to growing demands for first-contact care, chronic disease management, preventive services, and coordination of increasingly complex patient pathways [1].

From the perspective of occupational classification, the International Standard Classification of Occupations (ISCO-08) identifies generalist medical practitioners, including family doctors, under code 2211. These professionals "diagnose, treat and prevent illness, disease, injury and other physical and mental impairments in humans through the application of modern medicine" and typically work in settings that ensure continuity and comprehensiveness of care [2]. Family physicians serve as the first point of contact for patients within the healthcare system and are responsible for addressing undifferentiated problems at an early stage, ensuring continuity of care, coordinating referrals, and providing person-centered and community-oriented services. European Union directives such as Directive 2005/36/EC and its amendment Directive 2013/55/EU establish the requirements for medical specialization in FM [3,4]. These include a minimum of three years of structured training (including both hospital and ambulatory care experience), and the acquisition of core competencies such as independent clinical decision-making, communication skills, interdisciplinary collaboration, and ethical medical practice. WONCA Europe outlines eleven key characteristics of the discipline, which are operationalized into six core competencies: primary care management, person-centered care, specific problem-solving skills, a comprehensive approach, community orientation, and a holistic view of the patient [1].

While FM is widely recognized as a clinical specialty in most European health systems, its academic foundation have developed more unevenly across Central and Eastern Europe (CEE). Academic FM refers not only to the inclusion of the discipline in teaching curricula but also to its institutionalization in university structures, the conduct of research, and the presence of dedicated scientific organizations [5,6]. From a methodological standpoint, FM holds a unique position among medical disciplines. It integrates biomedical, behavioral, and social science approaches to understand and manage

cinske, bihejvioralne i društveno-naučne pristupe kako bi razumela i upravljala negom pacijenata u kontekstu porodice i zajednice. To podrazumeva svest stanovništva, dugoročnu negu, preventivne intervencije i holistički pristup bolesti [6]. Nakon političkih transformacija 1980-ih i 1990-ih, mnoge postkomunističke zemlje pokrenule su reforme sa ciljem uspostavljanja PM kao praktičnog modela za pružanje PZZ, ali i kao samostalne akademske discipline. U gotovo svim zemljama Centralne i Istočne Evrope katedre za PM formirane su unutar medicinskih fakulteta, dok su nastavni planovi i programi osnovnih i postdiplomskih studija prilagođeni u skladu sa tim [5].

U Poljskoj je PM formalno uvedena početkom 1990-ih, nakon društveno-političke tranzicije koja je usledila nakon pada komunizma. Poreklo porodične medicine u Poljskoj može se pratiti do sastanka održanog 23. juna 1992. godine, kada se trideset četvoro lekara okupilo kako bi osnovalo Kolegijum porodičnih lekara u Poljskoj (KLRwP, polj. *Kolegium Lekarzy Rodzinnych w Polsce*), instituciju koja promoviše strategiju integracije porodičnih lekara u sistem javnog zdravlja [7–9]. Poljska PM, modelovana prema sistemima primarne zdravstvene zaštite u Velikoj Britaniji i Holandiji, postepeno je zamenila prethodni poliklinički model. Pre tog procesa, pristup zdravstvenoj zaštiti često je bio neujednačen, dominirali su gradski klinički centri, a prisutne su bile i koruptivne prakse koje su stavljale pacijente iz provincije u nepovoljan položaj [9]. Tokom 1990-ih, KLRwP je uložio napore da se PM razvije kao priznata medicinska specijalnost. Do 1996. godine, nakon jednogodišnje evaluacije, KLRwP je stekao punopravno članstvo u Svetskoj organizaciji porodičnih lekara. Dalji napredak postignut je 1999. godine osnivanjem Poljskog društva za porodičnu medicinu (PTMR, polj. *Polskie Towarzystwo Medycyny Rodzinnej*) [10]. PTMR je od tada rukovodio razvojem nastavnih planova i programa, postdiplomskog obrazovanja, recenziranih publikacija, uključujući časopis *Lekarz POZ* (eng. *PHC Doctor*) [11], i afirmisanjem profesionalnog identiteta unutar discipline porodične medicine. Do svoje 25. godišnjice, 2017. godine, ova specijalnost je od kreatora politika sve više prepoznata kao isplativa i nezamenljiva komponenta primarne zdravstvene zaštite. Ovo je takođe označilo strukturnu transformaciju od prethodno fragmentiranog i urbano-centričnog modela ka savremenijem, pristupačnijem i na zajednicu usmerenog sistema, fokusiranog na praksu porodičnih lekara po uzoru na zapadnoevropske modele [9]. U 2022. godini, kada je disciplina proslavila svoju 30. godišnjicu, u izveštaju je zaključeno da je porodična medicina i dalje najpouzdaniji i najpozitivnije ocenjen sektor u poljskom zdravstvenom sistemu [8]. Tokom tri decenije, PM je konsolidovala svoj status priznate specijalističke i akademske oblasti, oblikujući zdravstvenu negu pacijenata u kontekstu porodica i zajednica. To uključuje svest na nivou populacije, dugoročnu negu, preventivne intervencije i holistički pristup bolesti [6]. Nakon političkih transformacija 1980-ih i 1990-ih, mnoge postkomunističke zemlje pokrenule su reforme sa ciljem uspostavljanja PM kao praktičnog modela za pružanje PZZ, ali i kao samostalne akademske discipline. U gotovo svim zemljama Centralne i Istočne Evrope, katedre za PM formirane su unutar medicinskih fakulteta, a nastavni planovi i programi osnovnih i postdiplomskih studija ažurirani su u skladu sa tim [5].

In Poland, FM was formally introduced in the early 1990s, following the socio-political transition after the fall of communism. The origins of FM in Poland can be traced to a meeting on 23rd June 1992, when thirty-four physicians convened to establishThe College of Family Physicians in Poland (KLRwP, pol. *Kolegium Lekarzy Rodzinnych w Polsce*) as a strategy-promoting institution for the integration of family doctors into the public health system [7–9]. Polish FM, modeled on PHC systems in the UK and the Netherlands, gradually replaced the former polyclinic model. Prior to this process, access to care was often inequitable, dominated by urban clinical centres and burdened by corrupt practices that disadvantaged provincial patients [9]. Throughout the 1990s, the KLRwP galvanized efforts to develop FM as a recognized medical specialty. By 1996, after a year-long evaluation, the KLRwP achieved full membership in the WONCA. In 1999, further advancement was achieved through the creation of the Polish Society of FM (PTMR, pol. *Polskie Towarzystwo Medycyny Rodzinnej*) [10]. The PTMR has since led development of training curricula, postgraduate education, peer-reviewed publications such as the *Lekarz POZ* (eng. *PHC Doctor*) journal [11], and fostering professional identity within the discipline. By its 25th anniversary in 2017, the specialty had gained increasing recognition from policymakers as both cost-effective and indispensable within the framework of primary healthcare. This also marked the structural transformation from a previously fragmented and urban-centric model to a more modern, accessible, and community-oriented system, centered around family physicians' practices modelled after Western European systems [9]. In 2022, as the discipline celebrated its 30th anniversary, the report concluded that FM remained the most trusted and positively rated sector within Polish healthcare [8]. Over three decades, FM has matured into a recognized specialty and academic field, shaping PHC and influencing health policy at the national level.

The study aimed to describe FM specialty in Poland using a case study approach and identify its strengths and challenges in the national context.

ći primarnu zdravstvenu zaštitu i značajno utičući na zdravstvenu politiku na nacionalnom nivou.

Ova studija je imala za cilj da opiše specijalizaciju iz PM u Poljskoj koristeći pristup studije slučaja i da identifikuje njene dobre strane i izazove u nacionalnom kontekstu.

METOD

Studija je sprovedena primenom eksplanatornog tipa studije slučaja, kako su ga opisali Krou i saradnici, sa ciljem istraživanja razvoja, implementacije i načina na koji trenutno funkcioniše PM u okviru sistema PZZ u Poljskoj [12]. Studija slučaja je odabrana zbog svoje prikladnosti za analizu složenih fenomena u stvarnom okruženju, unutar njihovih specifičnih političkih i institucionalnih konteksta. Ova studija se zasnivala isključivo na sekundarnim izvorima podataka (programskim dokumentima, nastavnim planovima i programima, statističkim izveštajima i recenziranoj literaturi). Shodno tome, dobijene rezultate treba razumeti prvenstveno kao interpretativne i deskriptivne, a ne kao empirijski merljive.

Izbor slučaja i ograničenja

Jedinica analize bio je nacionalni sistem PZZ-a u Poljskoj, sa posebnim osvrtom na ulogu i institucionalizaciju PM od njenog formalnog priznanja kao medicinske specijalnosti. Vremenski okvir obuhvata period od ranih 1990-ih, kada je PM uvedena, do najnovijih političkih dešavanja iz 2024. godine.

Izvori podataka

Podaci su prikupljeni iz različitih javno dostupnih izvora, uključujući: recenziranu literaturu o PM i PZZ u Poljskoj i Evropi; nacionalno zakonodavstvo i programska dokumenta koja su izdali Ministarstvo zdravlja i Nacionalni zdravstveni fond; nastavne planove i programe, kao i propise postdiplomskih programa obuke; statističke izveštaje strukovnih organizacija i vladinih baza podataka; sivu literaturu, uključujući argumentativne radove i stručne komentare poljskih medicinskih udruženja. Primarno prikupljanje podataka nije sprovedeno.

Analiza podataka

Podaci su sintetizovani korišćenjem kvazikvalitativne narativne sinteze, u skladu sa metodološkim okvirom koji su predložili Krou i saradnici [12]. Ovaj pristup je stavio akcenat na interpretativnu identifikaciju kontekstualnih faktora, strukturu sistema i politiku koja oblikuje PM unutar poljskog sistema PZZ-a. S obzirom na to da se studija oslanjala isključivo na sekundarne izvore, formalni postupak kodiranja nije primenjen. Ključne teme razvijane su iterativno i interpretirane u kontekstu postojećih međunarodnih modela i preporuka za PM.

METHODS

This study was conducted using an explanatory case study design, as described by Crowe et al. to investigate the development, implementation, and current functioning of FM within the PHC system in Poland [12]. The case study approach was chosen due to its suitability for exploring complex, real-world phenomena within their specific policy and institutional contexts. This study relied exclusively on secondary data sources (policy documents, training curricula, statistical reports, and peer-reviewed literature). As such, findings should be understood as interpretive and descriptive rather than empirically measured.

Case Selection and Boundaries

The unit of analysis was the national PHC system in Poland, with particular emphasis on the role and institutionalization of FM since its formal recognition as a medical specialty. The temporal scope covered the period from the introduction of FM in the early 1990s to the most recent policy developments as of 2024.

Data Sources

Data were collected from a variety of publicly available sources including: peer-reviewed literature on FM and PHC in Poland and Europe; national legislation and policy documents issued by the Ministry of Health and National Health Fund; postgraduate training program curricula and regulations; statistical reports from professional organizations and governmental databases; grey literature, including position papers and expert commentary from Polish medical associations. No primary data collection was conducted.

Data Analysis

The data were synthesized using quasi-qualitative narrative synthesis, guided by the framework proposed by Crowe et al. [12]. This approach emphasized the interpretive identification of contextual factors, system structure, and policy shaping the FM within Polish PHC. As the study relied exclusively on secondary sources, no formal coding procedure was applied. Key themes were iteratively developed and interpreted in relation to existing international models and recommendations for FM.

RESULTS

Family Medicine and Primary Healthcare in Poland

In Poland, FM plays a central role in the structure of PHC, which forms the foundation of the national health sys-

REZULTATI

Porodična medicina i primarna zdravstvena zaštita u Poljskoj

U Poljskoj, porodična medicina igra centralnu ulogu u strukturi primarne zdravstvene zaštite, koja predstavlja temelj nacionalnog zdravstvenog sistema. Usluge primarne zdravstvene zaštite pružaju se kroz široku mrežu ambulanti i pretežno se finansiraju putem predugovora sa Nacionalnim zdravstvenim fondom (NFZ; polj. *Narodowy Fundusz Zdrowia*) po principu plaćanja po pacijentu. Porodični lekari, zajedno sa specijalistima interne medicine i pedijatrije, ovlašćeni su za pružanje sveobuhvatnih usluga PZZ-a. Pravo na punu praksu kao pružalac usluga PZZ-a podrazumeva posedovanje specijalizacije iz PM ili upis na obuku iz PM. Pored toga, internisti i pedijatri mogu se kvalifikovati nakon završetka obaveznog kursa obuke specifičnog za PM. Međutim, samo priznatim lekarima dozvoljeno je da prikupljaju izjave pacijenata, što je ključni mehanizam za obezbeđivanje finansiranja u okviru predugovornog modela koji podrazumeva plaćanje po pacijentu, što ima značajne finansijske i organizacione posledice za prakse primarne zdravstvene zaštite. Od 2023. godine, tek oko 9.000 od ukupno 36.000 lekara zaposlenih u primarnoj zdravstvenoj zaštiti imalo je specijalizaciju iz porodične medicine i aktivno je pružalo usluge u ambulantama javnog zdravstvenog sistema [13]. Većinu pružalaca usluga primarne zdravstvene zaštite i dalje čine internisti i pedijatri. U tom kontekstu, iako je PM konceptualno u potpunosti usklađena sa ciljevima primarne zdravstvene zaštite, ona još uvek nije u potpunosti uspostavljena kao primarni profesionalni identitet unutar sistema [14].

Postdiplomska obuka iz porodične medicine u Poljskoj

Postdiplomski program obuke iz PM u Poljskoj je strukturisan program zasnovan na kompetencijama, osmišljen da pripremi lekare za samostalnu praksu u sistemu primarne zdravstvene zaštite [15]. Program reguliše Ministarstvo zdravlja i u skladu je sa nacionalnim zakonodavstvom o specijalističkoj obuci (Uredba ministra zdravlja od 4. maja 2023. o specijalizaciji lekara i stomatologa, *Journal of Laws* 2023, tačka 975). Standardno trajanje programa je četiri godine (48 meseci) i obuhvata kliničke rotacije, praksu pod nadzorom, teorijsku nastavu i obavezne kurseve sertifikacije. Program počinje jednonedeljim uvodnim modulom koji pokriva osnove PM, strukturu poljskog zdravstvenog sistema i zakonske propise relevantne za medicinsku praksu. Nakon toga, specijalizanti prolaze kroz niz kliničkih rotacija u ključnim specijalnostima koje su sadržane u oblasti porodične medicine. Rotacije obuhvataju internu me-

tem. PHC services are delivered through a broad network of outpatient clinics and are primarily financed through capitation-based contracts with the National Health Fund (NFZ; pol. *Narodowy Fundusz Zdrowia*). Family physicians, alongside specialists in internal medicine and pediatrics, are authorized to provide comprehensive PHC services. Eligibility for full practice as a PHC provider includes holding a specialization in FM or being enrolled in FM training. In addition, internists and pediatricians may qualify if they complete a mandatory FM-specific training course. However, only physicians with recognized eligibility are permitted to collect patient declarations - a key mechanism for securing funding under the capitation model, leading to financial and organizational consequences for PHC practices. As of 2023, only approximately 9,000 out of 36,000 physicians working in PHC held a specialization in family medicine and actively practiced in public outpatient settings [13]. The majority of PHC providers continue to be internists and pediatricians. In this context, while FM is conceptually aligned with the goals of PHC, it is not yet fully established as the primary professional identity within the system [14].

Postgraduate Training in Family Medicine in Poland

The postgraduate training program in FM in Poland is a structured, competency-based residency designed to prepare physicians for independent practice within the primary healthcare system [15]. It is regulated by the Ministry of Health and aligned with national legislation on specialist training (Regulation of the Minister of Health of 4th May 2023 on the specialization of physicians and dentists, *Journal of Laws 2023, item 975)*. The standard duration of the program is four years (48 months), combining clinical rotations, supervised practice, theoretical instruction, and mandatory certification courses. The program begins with a one-month introductory module covering the fundamentals of FM, the structure of the Polish healthcare system, and legal regulations relevant to medical practice. Following this, residents complete a series of clinical rotations across key specialties that reflect the scope of family practice. These include internal medicine (6 months), pediatrics (4 months), obstetrics and gynecology (2 months), psychiatry (2 months), dermatology (1 month), otolaryngology and ophthalmology (1 month, combined), emergency medicine (3 months), and a 2-month combined rotation in geriatrics, rehabilitation, and palliative care. A central component of the training consists of at least 18 months of supervised practice in accredited FM clinic. During this period, residents gain experience in delivering continuous,

dicinu (6 meseci), pedijatriju (4 meseca), ginekologiju i akušerstvo (2 meseca), psihijatriju (2 meseca), dermatologiju (1 mesec), otorinolaringologiju i oftalmologiju (1 mesec, kombinovano), urgentnu medicinu (3 meseca) i dvomesečnu kombinovanu rotaciju iz gerijatrije, rehabilitacije i palijativne nege. Centralna komponenta obuke obuhvata najmanje 18 meseci prakse pod nadzorom u akreditovanoj klinici. Tokom ovog perioda, specijalizanti stiču iskustvo u pružanju kontinuirane, na pacijenta usmerene nege, uključujući sve starosne grupe i različita zdravstvena stanja. Obuka naglašava prevenciju, ranu dijagnostiku, lečenje hroničnih bolesti, unapređenje zdravlja i koordinaciju pružanja nege unutar zdravstvenog sistema. Program obuhvata najmanje 320 sati teorijske nastave, koja pokriva teme kao što su komunikacijske veštine, kliničko rasuđivanje, javno zdravlje, etika i praksa zasnovana na dokazima. Polaznici su takođe obavezni da završe sertifikovane kurseve životne podrške, uključujući osnovnu životnu podršku (BLS) i naprednu životnu podršku (ALS). Program se završava nacionalnim specijalističkim ispitom (PES, polj. *Państwowy Egzamin Specjalizacyjny*), kojim se procenjuju medicinsko znanje, kliničko rasuđivanje i spremnost za samostalnu praksu kao lekara porodične medicine. Iako se poljski program specijalizacije eksplicitno ne poziva na međunarodne okvire, kao što su oni koje je razvio evrospki ogranak Svetske organizacije porodičnih lekara (WONCA Europe), on je usko usklađen sa Direktivom Evropske unije 2005/36/EC (izmenjenom i dopunjenom Direktivom 2013/55/EU), koja definiše formalne zahteve za postdiplomsku obuku u opštoj medicinskoj praksi. U praktičnom smislu, poljski nastavni plan i program pokrivaju oblasti definisane kroz šest osnovnih kompetencija prema Svetskoj organizaciji porodičnih lekara. Ipak, u poređenju sa postdiplomskim sistemima obuke u medicini u drugim evropskim zemljama, jasno se uočavaju određena područja u kojima poljski program može biti unapređen [16]. Primećuje se da obuci, koja formalno jeste zasnovana na kompetencijama, nedostaje strukturisan sistem longitudinalne procene koji kontinuirano prati napredak specijalizanata tokom celog programa. Za razliku od zemalja poput Ujedinjenog Kraljevstva i Holandije, gde polaznici prolaze kroz stalnu evaluaciju putem procena na radnom mestu, strukturisanih povratnih informacija i korišćenja elektronskih portfolija, poljski sistem se pretežno oslanja na nacionalni specijalistički ispit (PES) [15]. Takođe, upotreba validiranih instrumenata za procenu kliničkih veština, komunikacije i profesionalnog ponašanja je ograničena. Pored toga, učestvovanje u programima za razvoj trenera nije obavezno, što može doprineti varijabilnosti u kvalitetu supervizije i povratnih informacija tokom čitavog perioda obuke [16].

patient-centered care across all age groups and conditions. The training emphasizes prevention, early diagnosis, management of chronic diseases, health promotion, and coordination of care within the health system. The program includes a minimum of 320 hours of theoretical instruction, covering topics such as communication skills, clinical reasoning, public health, ethics, and evidence-based practice. Trainees are also required to complete certified life support courses, including Basic Life Support (BLS) and Advanced Life Support (ALS). The program ends with a national specialization examination (PES, pol. *Państwowy Egzamin Specjalizacyjny*), which assesses medical knowledge, clinical judgment, and readiness for autonomous practice as a family physician. Although the Polish specialization program does not explicitly refer to international frameworks such as those developed by WONCA Europe, it aligns closely with the European Union's Directive 2005/36/EC (as amended by Directive 2013/55/EU), which outlines formal requirements for postgraduate training in general medical practice. In practical terms, the Polish curriculum covers the domains specified in WONCA's six core competencies. However, when compared to postgraduate FM training systems in other European countries, certain areas for improvement in the Polish program become apparent [16]. Notably, while the training is formally competency-based, it lacks a structured system of longitudinal assessment that monitors the resident's progress throughout the entire program. Unlike in countries such as the United Kingdom and the Netherlands, where trainees undergo continuous evaluation through workplace-based assessments, structured feedback, and the use of electronic portfolios, the Polish system relies primarily on a PES [15]. There is also limited use of validated tools to assess clinical skills, communication, and professional behavior. Furthermore, participation in trainer development programs is not mandatory, which may contribute to variability in the quality of supervision and feedback during training [16].

Challenges Facing Family Medicine in the Polish Primary Healthcare System

Despite more than three decades of family medicine serving as a cornerstone of primary healthcare in Poland, the discipline continues to face workforce, PR, and policy-related challenges [14]. One of the most pressing concerns is the chronic shortage and unequal distribution of primary care physicians. While Poland's public spending on primary healthcare is among the highest in the Organization for Economic Cooperation and Development (OECD) (17% compared to the OECD25 average of 13%), the country

Izazovi sa kojima se suočava porodična medicina u poljskom sistemu primarne zdravstvene zaštite

Uprkos tome što porodična medicina više od tri decenije predstavlja temelj primarne zdravstvene zaštite u Poljskoj, ova disciplina i dalje se suočava sa izazovima vezanim za radnu snagu, odnose sa javnošću i zdravstvenu politiku [14]. Jedan od najozbiljnijih problema predstavlja hronični nedostatak i neujednačena raspodela lekara u primarnoj zdravstvenoj zaštiti. Iako je javna potrošnja Poljske na primarnu zdravstvenu zaštitu među najvišim u Organizaciji za ekonomsku saradnju i razvoj (OECD) – 17% u poređenju sa prosekom OECD25 od 13% – zemlja i dalje zaostaje po broju lekara po stanovniku, sa samo 3,4 lekara na 1.000 stanovnika. Posebno zabrinjava izuzetno nizak udeo lekara opšte prakse, koji čine svega 8% ukupnog broja lekara u Poljskoj, u poređenju sa prosekom OECD33 od 23% [17].

Privlačnost porodične medicine kao specijalnosti značajno varira od zemlje do zemlje i oblikovana je sistemskim, obrazovnim i ličnim faktorima. Međunarodne studije ukazuju na to da se lični razlozi vezani za stil života, uključujući ravnotežu između profesionalnog i privatnog života, manji broj noćnih i vikend smena, kao i mogućnost provođenja više vremena sa porodicom, nalaze među najuticajnijim faktorima pri izboru porodične medicine [14,18–21]. Razlozi koje odvraćaju mlade lekare od izbora porodične medicine uključuju nedostatak prestiža, visoko administrativno opterećenje, zahteve pacijenata za nepotrebnim izveštajima ili receptima i ograničene mogućnosti za supspecijalizaciju. Pored toga, prisustvo pozitivnih uzora i integracija porodične medicine u nastavni plan i program osnovnih studija smatraju se odlučujućim faktorima u oblikovanju stavova prema ovoj disciplini [18,19,20]. U Poljskoj se primećuje slična dinamika. Multicentrična studija preseka, koja je obuhvatila više od 2.000 studenata medicine sa pet univerziteta, pokazala je da interesovanje za porodičnu medicinu raste tokom studija (17% u prvoj godini, 30% u šestoj) što ukazuje na pozitivan uticaj kliničkog iskustva [20]. Najuticajniji faktor pri izboru porodične medicine bila je mogućnost profesionalnog razvoja, zatim intelektualni izazov i povoljna ravnoteža između posla i privatnog života. Međutim, studenti koji su odbili PM naveli su ograničene mogućnosti rada u bolničkom okruženju, percipiran birokratski pritisak i nedostatak fleksibilnosti pri promeni specijalnosti. Ovi rezultati ukazuju na to da bi, kako bi se povećala privlačnost PM u Poljskoj, reforme trebalo da se usmere na veće uključivanje PM u dodiplomske programe, unapređenje vidljivosti i percipiranog statusa discipline, kao i na pružanje strukturisanih podsticaja tokom postdiplomskih studija.

still lags in physician density, with only 3.4 doctors per 1,000 population. Of particular concern is the extremely low proportion of general practitioners - only 8% of all doctors in Poland, as compared to the OECD33 average of 23% [17].

The attractiveness of FM as a specialty varies significantly across countries, shaped by systemic, educational, and personal factors. International studies emphasize that personal lifestyle considerations, such as work-life balance, fewer night and weekend shifts, and the ability to spend more time with family are among the most influential reasons for choosing FM [14,18–21]. Concerns that deter young doctors from choosing FM include a lack of prestige, high administrative burden, patient demands for unnecessary reports or prescriptions, and insufficient opportunities for subspecialization. Moreover, the presence of positive role models and the integration of FM into the undergraduate curriculum are reported to be decisive in shaping attitudes toward the discipline [18,19,20]. In Poland, similar dynamics are observed. A multicenter cross-sectional study involving over 2,000 medical students from five universities found that interest in FM increases during the course of medical education - from 17% in the first year to 30% in the sixth, indicating the positive impact of clinical exposure [20]. The most influential factor for choosing FM was the opportunity for professional development, followed by intellectual challenge and a favorable work-life balance. However, students who rejected FM cited limited opportunities to work in hospital settings, perceived bureaucratic burdens, and a lack of flexibility in switching specialties. These findings suggest that to enhance the appeal of FM in Poland, reforms should focus on increasing its presence in undergraduate curricula, improving the visibility and perceived status of FM, and offering structural incentives during postgraduate training.

Although admissions to medical programs have reached record highs - over 10,000 students in the 2024/2025 academic year, many FM residency positions remain unfilled. A key reason might be the persistently low prestige of FM among students, often reinforced by negative perceptions during training. Extra financial incentives were introduced in 2023, including higher base salaries for priority specialties such as FM. These measures represent a step forward, yet they have not led to significant improvements in recruitment. Given the long pathway from medical school to independent practice, such measures alone are unlikely to yield prompt results. Crucially, efforts to enhance the attractiveness of FM are hindered by a lack of systematic data on medical career preferences and the real-world impact of incentive programs [14].

Iako je broj upisa na medicinske programe dostigao rekordno visoke vrednosti – preko 10.000 studenata u akademskoj 2024/2025. godini – mnoga mesta za specijalizaciju iz porodične medicine i dalje su nepopunjena. Primarni razlog za ovu pojavu može biti kontinuirano nizak ugled PM među studentima, koji je često dodatno pojačan negativnim percepcijama sticanim tokom studija. Dodatni finansijski podsticaji uvedeni su 2023. godine, uključujući povećanje osnovnih plata za prioritetne specijalnosti, među kojima je i porodična medicina. Ove mere predstavljaju značajan korak napred, ali nisu dovele do primetnog poboljšanja u regrutovanju. S obzirom na dug put od medicinskog fakulteta do samostalne prakse, malo je verovatno da će ovakve mere same po sebi doneti brze rezultate. Ključni izazov u naporima za povećanje privlačnosti PM predstavlja nedostatak sistematskih podataka o preferencijama u vezi sa medicinskom karijerom i o uticaju programa podsticaja na stvarni život [14].

Zadovoljstvo pacijenata uslugama primarne zdravstvene zaštite

U poljskom zdravstvenom sistemu, porodični lekari predstavljaju ključnu komponentu primarne zdravstvene zaštite, gde rade zajedno sa internistima i pedijatrima kako bi pružili sveobuhvatnu negu pacijentima tokom prvog kontakta. Međutim, trenutne organizacione strukture i sistemi izveštavanja ne prave razliku između ovih grupa pružalaca usluga u pogledu pružanja nege ili evaluacije njihovog rada. Kao rezultat toga, većina dostupnih podataka o zadovoljstvu pacijenata odnosi se pretežno na primarnu zdravstvenu zaštitu u celini, bez izdvajanja iskustava specifičnih za porodičnu medicinu. Ovo strukturno ograničenje otežava procenu posebnog doprinosa lekara porodične medicine stepenu zadovoljstva pacijenata. Stoga se ovaj odeljak fokusira na opšte zadovoljstvo pacijenata u okviru primarne zdravstvene zaštite, uz napomenu da rezultati odražavaju zajednički učinak svih relevantnih pružalaca usluga, uključujući i one obučene za porodičnu medicinu.

Prema studiji „Kvalitet i troškovi primarne zdravstvene zaštite u Evropi“ (QUALICOPC), poljski pacijenti generalno prijavljuju pozitivna iskustva sa uslugama primarne zdravstvene zaštite, posebno u oblastima kvaliteta nege i komunikacije između pacijenta i lekara [22]. Najveći stepen zadovoljstva kod pacijenata bio je povezan sa međuljudskim aspektima nege – pacijenti su cenili jasna objašnjenja, spremnost lekara da ih pažljivo sasluša i sposobnost lekara da iskaže empatiju. Primetno je da je indeks ispunjenih očekivanja kada je kvalitet nege u pitanju bio najviši među ocenjenim domenima, a potom su sledili ravnopravnost, kontinuitet i pristupačnost. Iako su pacijenti pristupačnost rangirali

Satisfaction of patients with primary healthcare services

In the Polish healthcare system, family physicians are a core component of PHC, working alongside internists and pediatricians to provide comprehensive first-contact care. However, the current organizational and reporting structures do not distinguish between these provider groups in service delivery or evaluation. As a result, most available data on patient satisfaction refer broadly to PHC services as a whole, without isolating experiences specific to FM. This structural limitation makes it difficult to assess the distinct contribution of family physicians to patient satisfaction. Therefore, this section focuses on general patient satisfaction within PHC, recognizing that the findings reflect the shared performance of all eligible providers, including those trained in family medicine.

According to the Quality and Costs of Primary Care in Europe (QUALICOPC) study, Polish patients generally report positive experiences with PHC services, especially in the domains of quality of care and patient-doctor communication [22]. The highest satisfaction was associated with interpersonal aspects of care - patients valued clear explanations, attentive listening, and the physician's ability to show empathy. Notably, the met expectation index (MEI) for quality of care was the highest among evaluated domains, followed by equity, continuity, and accessibility. Despite accessibility being ranked as the most important attribute by patients, it also showed the greatest potential for improvement, highlighting systemic shortcomings in timely and convenient access to services. The study revealed a mismatch between patient preferences and experiences in areas such as involvement in decision-making and the opportunity to discuss psychosocial concerns during consultations. Overall, the findings emphasize the importance of continued investment in communication skills training and patient-centered approaches for PHC physicians. Polish patients' satisfaction with family doctors seems to be primarily shaped by the quality of interpersonal interactions, rather than technical competencies or contextual factors alone [23]. Expressions of dissatisfaction were more often linked to contextual aspects of care, such as waiting times or access barriers, whereas positive feedback focused on physicians' personal qualities and communication style. These patterns are substantiated by another analysis from the Polish arm of the QUALICOPC project, which explored both patient and physician perspectives on PHC services [24]. Consistent with later findings [22], the study confirmed that patients reported the highest satisfaction in domains related to interpersonal aspects of

kao najvažniji atribut, upravo je ona pokazala najveći potencijal za unapređenje, ukazujući na sistemske nedostatke u blagovremenom i praktičnom pristupu uslugama. Studija je takođe otkrila nesklad između preferencija pacijenata i njihovih iskustava u oblastima kao što su učestvovanje u donošenju odluka i mogućnost razgovora o psihosocijalnim pitanjima tokom pregleda. Generalno, ovi rezultati naglašavaju značaj kontinuiranog ulaganja u obuku lekara PZZ-a iz oblasti komunikacijskih veština i primene pristupa usmerenog na pacijenta. Čini se da je zadovoljstvo poljskih pacijenata radom porodičnih lekara pretežno uslovljeno kvalitetom međuljudskih interakcija, a ne isključivo tehničkim kompetencijama ili kontekstualnim faktorima [23]. Nezadovoljstvo je češće izražavano u vezi sa kontekstualnim aspektima nege, kao što su vreme čekanja ili prepreke u pristupu sistemu, dok su se pozitivne povratne informacije odnosile na lične kvalitete lekara i njihov stil komunikacije. Ove obrasce potvrđuje i dodatna analiza poljskog ogranka projekta QUALICOPC, koja je istraživala perspektive kako pacijenata tako i lekara u vezi sa pružanjem usluga iz oblasti PZZ-a [24]. U skladu sa kasnijim nalazima [22], studija je potvrdila da su pacijenti prijavili najveći stepen zadovoljstva u oblastima koje se odnose na međuljudske aspekte nege, naročito kvalitet i ravnopravnost, dok je istovremeno istaknuto da je potrebno unaprediti pristupačnost. Važno je napomenuti da je studija takođe pokazala da duže trajanje pregleda, ruralna lokacija i veće iskustvo lekara pozitivno koreliraju sa stepenom zadovoljstva pacijenta, čime se dodatno naglašava značaj ulaganja vremena i kontinuiranog oblikovanja iskustava pacijenata. Iako su pacijenti pozitivno ocenili osnovne aspekte pružanja nege, lekari su iskazali kritičnije stavove, posebno u pogledu koordinacije i sveobuhvatnosti nege, što ukazuje na sistemski jaz između zadovoljstva koje prijavljuju pacijenti i učinka koji percipiraju pružaoci usluga.

I druge studije su na sličan način istakle centralnu ulogu koju međuljudski faktori, poput empatije, aktivnog slušanja i jasne komunikacije, imaju u oblikovanju zadovoljstva pacijenata na svim nivoima nege [25,26]. Iako poljski pacijenti generalno prijavljuju zadovoljavajuća iskustva sa uslugama primarne zdravstvene zaštite, i dalje postoje značajne razlike u poređenju sa specijalističkom ambulantnom negom [25]. Kao što je pokazala nedavna velika onlajn studija preseka, pacijenti su manje povoljno ocenili konsultacije sa lekarima primarne zdravstvene zaštite u oblastima koje se odnose na emocionalnu podršku, jasnoću komunikacije i angažovanost lekara. Percepcija lekara opšte prakse podrazumeva pružanje manje detaljnih objašnjenja, ograničenu brigu za širu dobrobit pacijenata i manje mogućnosti za razgovor o psihološkim pitanjima ili problemima ve-

care, particularly quality and equity, while highlighting accessibility as an area needing improvement. Importantly, the study also identified that longer consultation times, rural practice settings, and greater physician experience were positively associated with patient satisfaction, reinforcing the significance of time investment and relational continuity in shaping patients' experiences. Although patients rated core elements of care delivery positively, physicians expressed more critical views, especially regarding care coordination and comprehensiveness, suggesting a systemic disconnect between patient-reported satisfaction and provider-perceived performance.

Other studies have similarly emphasized the central role of interpersonal factors, such as empathy, active listening, and clear communication in shaping patient satisfaction across levels of care [25,26]. While Polish patients generally report satisfactory experiences with PHC services, notable differences remain when compared to specialist ambulatory care [25]. As demonstrated in a recent large-scale web-based cross-sectional study, patients rated PHC consultations less favorably in domains related to emotional support, clarity of communication, and physician engagement. FM doctors were often perceived as providing less detailed explanations, showing limited concern for patients' broader well-being, and offering fewer opportunities to discuss psychological or coping-related concerns [25]. Findings from local studies conducted in small Polish communities also reinforce the role of interpersonal factors in shaping patient satisfaction within PHC [26]. In a comparative analysis of patient experiences in public and private PHC centers in the Lubelskie Voivodeship, trust in the physician, the accuracy of diagnosis, and the quality of patient-staff interactions were strongly associated with continued use of services. Older patients, in particular, emphasized the importance of kindness, compassion, and attentiveness, not only from doctors but also from nurses, highlighting the relational nature of satisfactory care. The study further confirmed that negative perceptions were often linked to poor communication, lack of information about treatment progress, or feelings of being disregarded by medical personnel. Importantly, differences in patient satisfaction were not primarily attributed to the public or private nature of the healthcare provider, but rather to perceived accessibility, infrastructure quality, and interpersonal relationships. This aligns with previous research indicating that satisfaction is driven less by the technical or administrative structure of care and more by the patient's personal experience during the consultation [22,24].

zanim za suočavanje sa stresom [25]. Rezultati lokalnih studija sprovedenih u manjim poljskim zajednicama takođe potvrđuju značaj međuljudskih faktora u oblikovanju zadovoljstva pacijenata u PZZ [26]. U komparativnoj analizi iskustava pacijenata u javnim i privatnim centrima primarne zdravstvene zaštite u vojvodstvu Lublin, poverenje u lekara, tačnost dijagnoze i kvalitet interakcije između pacijenta i osoblja bili su snažno povezani sa kontinuiranim korišćenjem usluga. Stariji pacijenti su posebno isticali značaj ljubaznosti, saosećanja i pažnje, ne samo od strane lekara, već i od strane medicinskih sestara, naglašavajući relacijsku prirodu zadovoljavajuće nege. Studija je dodatno potvrdila da su negativne percepcije često povezane sa slabom komunikacijom, nedostatkom informacija o napretku u lečenju ili osećajem zanemarivanja od strane medicinskog osoblja. Važno je naglasiti da razlike u zadovoljstvu pacijenata nisu primarno povezane sa javnim ili privatnim karakterom pružaoca zdravstvenih usluga, već sa percipiranom dostupnošću, kvalitetom infrastrukture i međuljudskim odnosima. Ovo se poklapa sa prethodnim istraživanjima koja ukazuju na to da zadovoljstvo pacijenata manje zavisi od tehničke ili administrativne strukture nege, a više od ličnog iskustva tokom pregleda [22,24].

ZAKLJUČAK

PM funkcioniše kao priznata specijalnost u poljskom zdravstvenom sistemu od ranih 1990-ih, doprinoseći transformaciji primarne zdravstvene zaštite sa fragmentiranog i bolnički orijentisanog modela ka pristupačnijoj strukturi orijentisanoj ka zajednici. Uprkos ovim postignućima, broj lekara porodične medicine ostaje nesrazmerno nizak unutar sistema primarne zdravstvene zaštite. Studija slučaja je identifikovala nekoliko prednosti trenutnog modela porodične nege u Poljskoj, uključujući njegovu formalnu institucionalizaciju, usklađenost sa evropskim standardima obuke i visok nivo poverenja pacijenata povezan sa međuljudskim aspektima nege. Međutim, trajni izazovi uključuju nedostatak radne snage, ograničenu privlačnost specijalnosti među diplomcima medicine i nedoslednosti u kvalitetu postdiplomske obuke. Da bi se osigurala dugoročna održivost i efikasnost porodične nege u Poljskoj, neophodne su ciljno usmerene reforme. Pod time se podrazumeva unapređenje kvaliteta i vidljivosti obuke iz PM, potpunija integracija porodične medicine u dodiplomsko obrazovanje, promocija njenog profesionalnog identiteta i uklanjanje prepreka za zapošljavanje i zadržavanje kadrova. Ključno je da napori za jačanje porodične medicine ne budu vođeni isključivo programskom politikom, već i zasnovani na iskustvima kako pružalaca usluga, tako i pacijenata unutar sistema PZZ-a.

CONCLUSION

FM has operated as a recognized specialty in the Polish healthcare system since the early 1990s, contributing to the transformation of PHC from a fragmented and hospital-centric model to a more accessible, community-oriented structure. Despite these achievements, the number of family physicians remains disproportionately low within the PHC system. The case study identified several strengths of the current FM model in Poland, including its formal institutionalization, alignment with European training standards, and the high level of patient trust associated with interpersonal aspects of care. However, persistent challenges include workforce shortages, the limited attractiveness of the specialty among medical graduates, inconsistencies in postgraduate training quality. To ensure the long-term sustainability and effectiveness of FM in Poland, targeted reforms are needed. These include improving the quality and visibility of FM training, integrating family medicine more fully into undergraduate education, promoting its professional identity, and addressing barriers to recruitment and retention. Importantly, efforts to strengthen family medicine should not only be policy-driven but also informed by the lived experiences of both providers and patients within the PHC system.

Acknowledgements: The author, Mateusz Guziak, acknowledges that the preparation of this manuscript was carried out during his research internship at the Laboratory for Strengthening Capacity and Performance of Health Systems & Workforce for Health Equity, Faculty of Medicine, University of Belgrade, Serbia. He wishes to express his sincere gratitude to Ms. Elżbieta Gelert, Director General of the Provincial Integrated Hospital in Elbląg (Wojewódzki Szpital Zespolony w Elblągu), and Ms. Hanicenta Rzepa, Coordinator of the Department of Obstetrics and Gynecology, for their valuable assistance and kind support in facilitating the internship.

Conflict of interest: None declared.

Zahvalnice: Autor, Mateuš Guzjak, priznaje da je priprema ovog rukopisa obavljena tokom njegove istraživačke prakse u Laboratoriji za jačanje kapaciteta i učinka zdravstvenih sistema i radne snage za zdravstvenu ravnopravnost, Medicinskog fakulteta Univerziteta u Beogradu, Srbija. Želi da izrazi svoju iskrenu zahvalnost gđi Elžbjeti Gelert, generalnoj direktorki Pokrajinske integrisane bolnice u Elblagu (Wojewódzki Szpital Zespolony w Elblągu), i gđi Haničenti Ržepi, koordinatorki Odeljenja za akušerstvo i ginekologiju, na njihovoj dragocenoj pomoći i ljubaznoj podršci u olakšavanju prakse.

Sukob interesa: Nije prijavljen.

LITERATURA / *REFERENCES*

1. Allen J, Gay B, Crebolder H, Heyrman J, Svab I, Ram P, et al. The European Definition Of General Practice / Family Medicine WONCA Europe 2023 Edition. 2023.
2. ISCO-08 [Internet]. 2008 [cited 2025 Jun 29]. International Standard Classification of Occupations (ISCO). Available from: https://ilostat.ilo.org/methods/concepts-and-definitions/classification-occupation/
3. Directive - 2005/36 - EN - EUR-Lex [Internet]. [cited 2025 Jun 29]. Available from: https://eur-lex.europa.eu/eli/dir/2005/36/oj/eng
4. Directive - 2013/55 - EN - EUR-Lex [Internet]. [cited 2025 Jun 29]. Available from: https://eur-lex.europa.eu/eli/dir/2013/55/oj/eng
5. Krztoń-Królewiecka A, Švab I, Oleszczyk M, Seifert B, Smithson WH, Windak A. The development of academic family medicine in central and eastern Europe since 1990. BMC Fam Pract [Internet]. 2013 Mar 19 [cited 2025 Apr 15];14(1):1–10. Available from: https://bmcprimcare.biomedcentral.com/articles/10.1186/1471-2296-14-37
6. Burditt AM. Defining family medicine as a scientific discipline. Canadian Family Physician [Internet]. 2006 Oct [cited 2025 Jun 29];52(10):1206. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC1783608/
7. Godycki-Ćwirko M, Windak A. KLRWP. [cited 2025 Jun 29]. Kolegium Lekarzy Rodzinnych w Polsce. Available from: https://klrwp.pl/informacje/historia
8. Wróbel P. Rynek Zdrowia. 2022 [cited 2025 Apr 15]. Medycyna rodzinna w Polsce ma 30 lat. Jak wypada jej bilans? Available from: https://www.rynekzdrowia.pl/Polityka-zdrowotna/Medycyna-rodzinna-w-Polsce-ma-30-lat-Jak-wypada-jej-bilans,233288,14.html
9. Bujko J. Remedium. 2017 [cited 2025 Apr 15]. Historia medycyny rodzinnej w Polsce - Remedium. Available from: https://remedium.md/publikacje/opinie/historia-medycyny-rodzinnej-w-polsce
10. PTMR [Internet]. [cited 2025 Jun 29]. Polskie Towarzystwo Medycyny Rodzinnej. Available from: https://ptmr.info.pl/about/
11. Czasopismo Lekarz POZ [Internet]. [cited 2025 Jun 29]. Available from: https://www.termedia.pl/Czasopismo/Lekarz_POZ-98
12. Crowe S, Cresswell K, Robertson A, Huby G, Avery A, Sheikh A. The case study approach. BMC Med Res Methodol [Internet]. 2011 [cited 2025 Jun 29];11:100. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC3141799/
13. Health Needs Map for the Period from January 1, 2022, to December 31, 2026. (Pl. Mapa potrzeb zdrowotnych na okres od 1 stycznia 2022 r. do 31 grudnia 2026 r.) [Internet]. Warsaw; 2021 [cited 2024 Dec 3]. Available from: https://dziennikmz.mz.gov.pl/DUM_MZ/2021/69/akt.pdf
14. Guziak M, Walkiewicz M, Nowicka-Sauer K, Šantrić-Milićević M. Future research directions on physicians in Polish primary healthcare: workforce challenges and policy considerations. Crit Public Health [Internet]. 2025 Dec 31 [cited 2025 Jun 29];35(1):2495687. Available from: https://www.tandfonline.com/doi/abs/10.1080/09581596.2025.2495687
15. Centrum Medyczne Kształcenia Podyplomowego. CMKP. 2023 [cited 2025 Jun 29]. Program specjalizacji w dziedzinie Medycyny Rodzinnej. Available from: https://www.cmkp.edu.pl/wp-content/uploads/2023/02/0713-program-1.pdf
16. Assessing family medicine trainees-what can we learn from the European neighbours? [cited 2025 Jun 29]; Available from: http://www.rcgp.org.uk
17. Health at a Glance 2023: OECD Indicators [Internet]. Paris: OECD Publishing; 2023 [cited 2024 Jun 7]. Available from: https://doi.org/10.1787/7a7afb35-en
18. Verulava T. Factors influencing medical students' choice of family medicine. Family Medicine & Primary Care Review [Internet]. 2022 [cited 2025 Jun 29];24(1):66–70. Available from: https://doi.org/10.5114/fmpcr.2022.113017
19. Akyön Ş. Determinants Of Choosing Family Medicine As A Specialty For Young Doctors. Ankara City Hospital Medical Journal. 2023 Mar 28;2.
20. Gowin E, Horst-Sikorska W, Michalak M, Avonts D, Buczkowski K, Lukas W, et al. The attractiveness of family medicine among Polish medical students. European Journal of General Practice [Internet]. 2014 Jun 26 [cited 2025 Apr 15];20(2):121–4. Available from: http://www.tandfonline.com/doi/full/10.3109/13814788.2013.826643
21. Jordan J, Brown JB, Russell G. Choosing family medicine What influences medical students? Can Fam Physician. 2003;49:1131–7.
22. Krztoń-Królewiecka A, Oleszczyk M, Windak A. Do Polish primary care physicians meet the expectations of their patients? An analysis of Polish QUALICOPC data. BMC Fam Pract [Internet]. 2020 Jun 23 [cited 2025 Jun 30];21(1):1–8. Available from: https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-020-01190-1
23. Marcinowicz L, Chlabicz S, Grebowski R. Patient satisfaction with healthcare provided by family doctors: Primary dimensions and an attempt at typology. BMC Health Serv Res [Internet]. 2009 Apr 16 [cited 2025 Jun 30];9(1):1–5. Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-9-63
24. Oleszczyk M, Krztoń-Królewiecka A, Schäfer WLA, Boerma WGW, Windak A. Experiences of adult patients using primary care services in Poland - A cross-sectional study in QUALICOPC study framework. BMC Fam Pract [Internet]. 2017 Nov 22 [cited 2025 Jun 30];18(1):1–13. Available from: https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-017-0665-6
25. Pochrzęst-Motyczyńska A, Ostrowski J, Sys D, Pinkas J, Religioni U. Patient Satisfaction in Primary and Specialised Ambulatory Healthcare: A Web-Based Cross-Sectional Study in the Polish Population. Healthcare 2025, Vol 13, Page 1147 [Internet]. 2025 May 14 [cited 2025 Jun 30];13(10):1147. Available from: https://www.mdpi.com/2227-9032/13/10/1147/htm
26. Przybylska D, Przybylski P, Drop B, Czarnocki K, Przybylski W, Drop K, et al. A comparison of the levels of satisfaction with the medical services provided by primary healthcare centers in selected communes. Polish Journal of Public Health [Internet]. 2016 May 8 [cited 2025 Jun 30];126(1):8–12. Available from: https://czasopisma.umlub.pl/pjph/article/view/1189