Original Contribution

Daily Life of a Turkish Medical Oncologist

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There are many changes occurring in the Turkish health care system, including but not limited to consolidation of public hospitals and administrative takeover of some university hospitals by the Ministry of Health. Because of its unique situation, Marmara University Hospital is at the center of these changes. The adaptation process will continue for another year or so, after which it is hoped that a better health care environment will have been created for patients with cancer in Turkey.

Introduction

Turkey is a country the size of Texas, with a population of 75 million, mostly located in Istanbul (13.2 million); Ankara, the capital (4.4 million); and Izmir, a busy Aegean port (2.7 million). Istanbul is divided by a sea channel that connects the Black Sea and the Sea of Marmara. Two thirds of its population live on the European side, which is the part of the city on the western side of the channel. This area of the city is generally considered to be more business oriented. The eastern part, where I live, called the Anatolian side, is mostly residential.[1]

Teaching of Medicine in Istanbul

I work at Marmara University, which is the only one of the seven state universities and three state medical schools in Istanbul located on the Anatolian side. There are also 47 private universities in Istanbul, most of them established in the last decade. Altogether, 54 universities exist, but medicine is taught at only four of them, two state universities and two private universities, one of each on each side of the channel. In the coming years, medicine will also be taught at several new private universities. The Marmara University was established in 1883 as a school of business by the late Ottoman Sultan Abdulhamid Khan. The medical school was added later on the Anatolian side in a landmark art nouveau building. Although the administrative offices and preclinical classrooms are still functioning in this building built in 1895, the medical school became the first modern medical school in the Ottoman Empire. The university was re-established as Marmara University in 1983.[2]

Cancer Incidence in Turkey

Incidences of cancer in Turkish males and females are approximately 260 and 160 in 100,000, respectively, roughly one third of the rates in Western Europe. Because the population is aging rapidly, these numbers are expected to double in the next several decades.[3] Therefore, the need for already scarce medical oncologists is enormous.[4] In males, the most common cancer is lung cancer. The incidence of lung cancer (68.9 in 100,000) is more than double the incidence of prostate cancer (28.9 in 100,000), the distant second cancer. Incidences of bladder, colorectal, and gastric cancers are slightly lower (21, 18.2, and 14.8 in 100,000, respectively). In females, the most common cancer is breast cancer. The incidence of breast cancer (37.6 in 100,000) is three times the rate for colorectal cancer (12.5 in 100,000), which is the second most common cancer. Slightly less common cancers for females are thyroid, endometrial, and lung cancers (108, 8.4, and 7.7 in 100,000, respectively).[3-6]

Status of Medical Oncology at Marmara University

Before I arrived from the United States in 1997, there were no formally trained medical oncologists at Marmara University Hospital (MUH), and medical oncologic care was provided to patients by nonmedical oncologists. Initially, many departments, including pulmonary; ear, nose, and throat; urology; and gynecology, did not refer oncology patients to me but instead preferred to treat the patients themselves. Over time, the department of medical oncology was established as the major provider of medical care to oncology patients. Today, at MUH, almost 95% of chemotherapy treatments for solid tumors are prescribed by medical oncologists. Fewer prostate, bladder, or thyroid cancers are seen by medical oncologists at MUH, because urologists use combined androgen blockage and intravesical therapy for prostate and bladder cancers, respectively. General surgeons and nuclear medicine specialists provide follow-up for patients with thyroid cancers. The remaining cancers represent our bread and butter.

Access to Cancer Care in Turkey

Access to chemotherapy drugs and oncology care in general is free to the Turkish working class through a system similar to Medicare. Economically disadvantaged citizens may have access through a different route similar to Medicaid (Sosyal Guvenlik Kurumu; Social Security Agency) if they are financially eligible. Some workers in private industries, forced by their employers to work unregistered to avoid payment of social security contributions, are not covered by the health care system. Also, small landowners in rural areas often cannot afford to register for Medicare but are not eligible for Yesil Kart (Identification of Underprivileged Status), Turkey's equivalent to Medicaid. Therefore, they are also uncovered. Together, they make up

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roughly 10% to 15% of the general population.[4] There are also some out-of-the-ordinary limitations to the use of newer technologies such as positron emission tomography scans (eg, cannot be used more frequently than once every 3 months, and only after documentation that there is a plan to change current treatment) and newer drugs such as sunitinib (eg, can be prescribed only to patients whose disease is refractory to interferon treatment), even among covered patients. However, Turkish physicians have an advantage over those in the United States; the shortage of commonly used chemotherapy drugs in the United States is not an issue in Turkey.[7]

Legal Struggle Between the Medical Faculty and Ministry of Health

At MUH, our day starts at 8 AM with educational meetings and multidisciplinary cancer care rounds. We have separate multidisciplinary meetings with general surgeons, thoracic surgeons, and orthopedists, each also attended by personnel from pathology, radiation oncology, pulmonary, radiology, and nuclear medicine. However, these meetings must end at 9 AM sharp for participants to be on time at the outpatient care offices, which remain open until 5 PM every day. Until recently, senior members of the staff were allowed to choose between part- and full-time status. Part-time physicians were allowed to serve 20 hours per week in the hospital. Consequently, they usually left at noon to go to their private offices and hospitals. Recently, part-time status has been abolished because of the popularly held belief among the public that unless a senior physician is paid, treatment will be provided by a resident or trainee. The abolition of part-time status has caused friction between the National Medical Association and the government. Eventually, a suit was filed in state court by the National Medical Association. As a result, the court decided for the abolition of part-time status for the benefit of the public, but it allowed physicians see patients privately after work hours (ie, 5 PM). The government then took this decision to the constitutional court, and, at the time of this writing, the court is in the process of finalizing the verdict. In the meantime, hospital administrators are putting a hold on monthly performance-based bonus payments to discourage physicians who insist on keeping their office practices open even after 5 PM.[8]

Health Care Consolidation Efforts by the Ministry of Health

The working hours of physicians are only one of the many changes that have taken place recently in the health system in general medicine and in oncology, in particular. Up until 2008, many interest groups, such as the municipalities, teachers, postal workers, local merchants, and policeman, had their own dedicated hospitals to serve them with some privileges. The government decided to consolidate them all under the state health authority. Now, the only hospitals that are not operated under the state health authority are the university hospitals. The university hospitals operate under the Higher Education Council, which consists primarily of academicians. The refusal of university hospitals to accept administration by the Ministry of Health was the subject of another debate. The government implemented performance-based payment of services to public hospitals. Public hospitals began to thrive as a result of their high-volume patient turnover (quantity of patients examined or procedures performed). In contrast, university hospitals received an increasing number of complex patient cases. Consequently, university hospitals struggled with the extra time and energy spent on each patient, which were not reflected in higher dedicated performance scores. This forced many university hospitals into bankruptcy, as they were not able to get additional payments for their extended services. The Ministry of Health then offered to take on the debt of a university hospital if the hospital would agree to be managed by the Ministry of Health. Although many university hospitals were offered bailouts, they all refused. Negotiations regarding MUH management by the Ministry of Health started in early 2010 and took a different path, as described below.

MUH As an Early Example of Management by the Ministry of Health

Istanbul is in an earthquake zone, and all public buildings undergo stress testing. The MUH building was found to be too weak to operate in this highly risky zone, and the hospital administrator was ordered to move the hospital immediately. Because the planned campus at the outer boundaries of the city was not going to be ready for another several years, a new state hospital was offered as a replacement. The hospital, which was 30 miles from the original location of MUH, was the biggest in Turkey. When the offer was made, this new state hospital was under construction as well. The offer to move to the hospital was rejected in a popular vote by the staff, who preferred to continue serving patients in the relatively stronger wings of the old hospital. Nevertheless, after an agreement between the Ministry of Health and the head of the university administration, the move to the new hospital took place in mid September 2010. It goes without saying that, as tenant, the managers of the new hospital were appointed by the Ministry of Health, which was the legal owner of the hospital building. At the time of this writing, after almost 10 months in the new building, the hospital is still not fully operational. Approximately 50% of the operating rooms are not functional, emergency services recently became available after more than 9 months of no emergency care, and until recently the oncology outpatient care unit had provided services in a provisional area dedicated to surgery. Despite all this, the major hurdles are not technical but administrative. The previously responsible authority (ie, the dean's office) and the current head of administration (ie, the chief medical officer, who was managing the affairs of the faculty) were responsible for the everyday running of the hospital. However, since the move, the chief medical officer is, in real terms, responsible for both duties and is still trying to find common ground with the Ministry of Health authorities in Ankara on issues like signing daily log books and giving permission to attend medical conferences. All of these issues supposedly will be resolved within the next few months, after which other pub-

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lic universities will be able to evaluate the advantages or disadvantages of operating under the auspices of the Ministry of Health.

Discussion

Several issues that have a day-to-day effect on our practices and that must be resolved at national level include:

- Better cancer registries to allocate local and limited resources toward the cancers that are more common.
- Easier access, with less bureaucracy, to newer treatment modalities.
- More effective means of serving poor patients from underprivileged areas and those who have oncologic needs.
- Trained ancillary personnel for support of patient care–related bureaucracy.
- Trained ancillary personnel for support of national and international research projects.
- Easier access to funds for research to compensate for the loss of income as a result of abstaining from income-raising clinical activities.

Despite shortcomings, approval by the public regarding the quality of general health care reached nearly 60% in 2010, which is an all-time high. Future efforts to smooth out problem areas should result in better services to patients and health care providers, and should enable Turkey to meet the health care standards of the developed world.

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Author's Disclosures of Potential Conflicts of Interest

The author indicated no potential conflicts of interest.

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References

1. Wikipedia: Istanbul. http://en.wikipedia.org/wiki/Istanbul

2. Marmara University: About Marmara. www.marmara.edu.tr/en/information/general-information

3. The Ministry of Health of Turkey: Cancer Control Department: Cancer Registry: Active registry continues in 8 provinces. www.kanser.gov.tr/index_en.php

4. The Ministry of Health of Turkey: E library: Turkish Health Statistics 2010. www.saglik.gov.tr/EN/belge/2-323/health-statistics-yearbook-2008.html?vurgu=health+statistics

5. Eser S: Cancer incidence in Turkey, in Tuncer M (ed): Cancer Control in Turkey. Ankara, Turkey, Ministry of Health Publication, 2007, pp 17-45

6. International Agency for Research on Cancer: Globocan 2008 Cancer Fact Sheet: Estimated cancer incidence in 2008. http://globocan.iarc.fr/factsheets/cancers/all.asp

7. National Cancer Institute: NCI Cancer Bulletin: Continued shortage of chemotherapy drugs causing concern. www.cancer.gov/ncicancerbulletin/011111/page2

8. Turkish Medical Association: The position declaration for general public toward the recent healthcare changes. www.ttb.org.tr/

What Patients Need to Know About Managing the Cost of Care

ASCO's *Managing the Cost of Cancer Care* booklet shares practical tips on financial planning before, during, and after treatment. Patients can learn about understanding the costs related to their care, find a list of questions to ask physicians about cost, and view a glossary of cost-related terms and a list of organizations offering help for people with cancer facing financial challenges. This booklet is also available in Spanish. Download the booklet at **cancer.net/managingcostofcare** or order free copies at **asco.org/store**.

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