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Primary Health Care: the Relational Aspects of Social Interaction between Family Doctors and People with Disabilities

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Abstract. *Strategic documents of the United Nations and the European Union express the belief that primary health care is a fundamental part of health care services and it must be accessible to all people and funded according to the means. Many research studies prove that enhancement of the primary health care system helps to effectively eliminate causes and risk factors for poor health and to prevent likely impairment of health in the future. However, the data of recent investigations demonstrate that the quality of health care services in Lithuania is much poorer than the average of the EU, and the institution of family doctors providing services of this type suffers from problems related to the efficiency of functioning. Therefore, it is worth investigating possible causes for this problem, to identify them and search for solutions. The paper presents the research that is aimed at examining one part of the aspects of the problem, specifically the relational aspects of social interaction between family doctors and people with disabilities from the point of view of people with disabilities and their relatives. 555 people with disabilities (PWD) and 540 respondents who had relatives with disabilities and took care of them (PWD_{care}) participated in the survey carried out in 2019–2020 and reported about their experience of social interaction with family doctors. The research indicated many positive tendencies, of which the most prominent was the satisfaction of the relationship, trust and understandment with family doctors. But*

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at the same time the research revealed some more problematic areas, such as the lack of family doctors' compassion and warmth to many patients. These results are important for improving the primary health care service and quality as well for strengthening the family doctors' education.

Keywords*: health care service, social interactions, healthcare quality, family doctor, people with disabilities*

1 Introduction

According WHO (Primary health, 2019), "primary health care is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities". It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing. In the European Union it is proclaimed that strong primary healthcare gives the foundation of a health system that is effective, efficient and responsive to patients' needs, furthermore, well performing primary care means less healthcare utilization overall and more focus on the quality and achievement of optimal health outcomes (European Commission, 2018).

In Lithuania the primary health care is considered to be a particularly important part of the healthcare system. Primary health care is a nonspecialized qualified service which is provided by a team of family doctors, general practitioners and other healthcare workers in a health clinic, a persons home or a foster institution (Sveikatos priežiūra Lietuvoje: ką svarbu žinoti kiekvienam, 2015, 12 p.). According to the concept of primary healthcare development (2007), 80 percent of health issues must be resolved in primary health care settings, thus the family doctor acquires a "goalkeeper" role (Dėl šeimos gydytojo modelio įgyvendinimo, 2016). Family doctor is the main specialist, who is the first one to meet the patient in the health system, and provides him with the required medical assistance and decides if the person requires secondary/ tertiary health care services, medical rehabilitation or any other health services, and in accordance with the procedure laid down by the law redirects the person to receive those services (Akbari et al., 2005). Thus, family doctors become important health care system workers, which patients have the most social interactions with.

Research shows a particular importance of social interaction between physicians and patients and admits, that a professional patient–physician relationship is a key factor of perceived healthcare quality (Janušonis, 2017; Piligrimienė & Bučiūnienė 2008; Štaras, Vedlūga & Kalvelytė, 2013; Papp et al, 2014; Jurgutis & Juknevičiūtė, 2012), requiring the physician to be compassionate, caring, and empathetic, and to build trust between both parties (Stringer, Ryan, Terry & Pike, 2019; Hashim, 2017). Studies done in Lithuania (Jerdiakova et al., 2020) show how important it is for patients to feel the doctors' attention and compassion. It appears that patients value the relational health service provision more than how the actual health care service is

being organized or coordinated. For them, attention, respect, confidentiality, privacy, compassion, communication and openness is important (Štaras et al, 2013). Patients put a lot of meaning to the empathy and interaction of the doctor, they value when the physician recognizes them, cares about their opinion, emotional state and social life (Jurgutis & Juknevičiūtė, 2012). When picking a family, the choice is often determined by their ability to communicate familiarly and matter-of-factly (Paulauskaitė, Rimkutė, Vaikasaitė & Randakevičienė, 2017). At the same time, research shows that relational aspects of social interaction between physicians and patients in some cases is quite problematic: patients' emotional and communicational needs are unmet in the social interaction with physicians (Kee, Khoo, Lim, & Koh, 2018; King & Hoppe, 2013). Older research on the situation in Lithuania in this respect show that patients rated their relationship with family practitioners positively (Misevičienė & Dregval, 2002). We lack newer studies, however we can determine the situation in Lithuania by the research on trust in physicians, as the latter greatly depends on the doctors' communication with patients – in Lithuania the trust in a doctor is much lower than in countries such as the Netherlands and Denmark, where the health system is trusted by 91.6 percent and 86.1 percent (in Lithuania –- 64.3 percent) (Matulevičiūtė & Balžekienė, 2016), patients trust family doctors a little more – 70 percent (quote Aukščiausioji audito institucija, 2018). These facts show that in recent years, there have also been problems in the relational aspects of social interaction between physicians and patients, as well as in other countries. This becomes a major challenge for the health system because when miscommunication occurs, it can have severe negative implications in clinical care such as impeding patient understanding, expectations of treatment, treatment planning, decreasing patient satisfaction of medical care, and reducing levels of patient hopefulness (Ha & Longnecker, 2010).

The situation in the health system becomes more complicated, when people with disabilities come into play. Global research shows that, in general, satisfaction with healthcare services among people with disabilities is lower compared to people without disabilities (Werner, Yalon-Chamovitz, Rinde & Heymann, 2017; Weise, Pollack, Britt & Trollor, 2016; Sharby, Martire & Maura Iversen, 2015; Lewis, Lewis, Leake, King & Lindemanne, 2016). And often the reason for this dissatisfaction is seen by researchers in relational aspects of social interaction between physicians and patients with disabilities. Research shows increased odds for communication barriers to healthcare services compared to persons without disabilities (Bauer et al., 2014); people with disabilities are more likely to experience ineffective patient–physician communication (Smith, 2009) and are less likely to be given the attention needed for addressing feelings and emotions, to understand the next steps of treatment and to receive a clear explanation (Marlow, Samuels, Jo & Mainous, 2019). Patients with disabilities emphasize the importance of physicians' listening, respectful behavior, explanation of treatment (Marlow et al., 2019), honesty and openness when giving information and consistency in provision of information (Ninnoni, 2019). People with

disabilities require, as Sullivan, Diepstra, Heng, Ally, Bradley, Casson, & Abells (2018) suggest, effective communication that meets their needs: address patients directly, find ways of engaging the patient, attend to both verbal and nonverbal cues, use the patient's preferred communication method, tools, etc. The doctors' understanding, sincerity and humanity is needed not only for people with disabilities, but also for their close ones, say, for the parents of children with disabilities (Vaškelytė, & Ragauskaitė, 2019).

As for relational aspects of social interaction between family doctors and patients with disabilities, trends in relationship dissatisfaction are observed. As family doctors say themselves, often they experience relational problems with patients with disabilities, i.e. with patients who have intellectual disabilities (Werner at al, 2017; Weise et al., 2016), communication disabilities (Stransky, Jensen & Morris, 2018), vision disabilities (Agaronnik, Campbell, Ressalam & Iezzoni, 2019), learning disabilities and epilepsy (Ninnoni, 2019). Some research shows, that the core process in the development of the patient–physician relationship in primary health care was bidirectional acceptance of patients with intellectual and developmental disabilities as unique individuals with their own goals and potential, when physicians had to adapt the way they practiced (Stringer et al., 2019) and avoided unconscious bias and making assumptions about patients' quality of life (Kripke, 2017). The importance of long-standing respectful communication and relation with family doctors is likewise emphasized by some parents of children with disabilities (O'Brien, Harvey, Howse, Reardon & Creswell, 2016).

It can be noticed, that the relational aspects of social interaction between family doctors and people with disabilities are not much analyzed from the perspective of people with disabilities and their close ones. Meanwhile, it is an exceptionally important primary healthcare quality factor, thus a deeper understanding of it could help to improve the situation of people with disabilities in this area and to train health professionals to work with them. Therefore, this article focuses on the issue above and aims to deepen the understanding of relational aspects of social interaction between family doctors and people with disabilities from the point of view of people with disabilities and their close ones.

2 Materials and Methods

In this paper, we use the subset of data from the 2019–2020 national survey aimed at understanding the situation of people with disabilities in the health care system from the point of view of people with disabilities and their close ones.

2.1 Participants

1095 respondents (555 PWD and 540 PWDcare) participated in this study. Almost half of the participants were from big cities (PWD – 44.8 %, PWDcare – 44.9 %), quarter of them were from cities – district centers (PWD – 24.5 %, PWDcare – 25 %) and the

rest were from other cities, towns, villages (PWD – 31.7 % and PWDcare – 30.1 %). The majority of respondents were female: 59.7 % PWD (n=330) and 78.7% PWDcare (n=424). Males were 40.3 % in PWD (n=223) and 21.3% in PWDcare (n = 115) groups. The age of participants ranged from 18 to 97 years (M = 51.7, SD = 17.97) in PWD and from 20 to 86 years (M = 49.1, SD =12.71) in PWDcare groups. Other important topic-specific characteristics are presented in Table 1.

Table 1

Characteristics of participants by group

Characteristics	Variable	PWD	PWDcare*
The nature of the disability	Moderate disability	63.4	58.7
	Severe disability	33.7	41.3
Disability acquisition	Congenital disability	25.4	30.3
	Acquired disability	74.6	69.7
Type of disability	Mental and behavior disorders	15.3	29.4
	Disease of the nervous system	26.3	23.3
	Disease of the circulatory system	17.5	21.1
	Neoplasms	7	9.6
	Endocrine, nutritional, and metabolic disease	10.3	9.4
	Disease of the blood and blood-forming organs, and certain disorders involving immune system	5.2	5
	Disease of musculoskeletal system and connective tissue	12.4	10
	Disease of digestive system	4	2.4
	Disease of eye and adnexa, ear and mastoid process	11.2	12.6
	Other	15.7	11.7
Living conditions	Good	66.2	77.6
	Satisfactory	30.6	20.7
	Bad	3.3	1.7
Need for home care	Requires constant maintenance/partial maintenance/can live without care)	25.2	43.9
	Requires partial maintenance	35.6	40.3
	Can live without care	39.2	15.8

Note. *Demographic characteristics of people with disability under the care

2.2 Sampling

In order to create equal opportunities for all people with disabilities and their relatives to participate in the survey, the Lithuanian Disability Forum (www.lnf.lt), uniting 14 nongovernmental organizations operating in Lithuania, focusing on people with disabilities (for example, the Lithuanian Society of the Deaf, the Lithuanian Society of the Disabled, and others) was approached for mediation. However, very few respondents responded. Nonetheless, a sufficient number of questionnaires was also

collected. Therefore, at the beginning of the survey collection nonprobability purposive sampling was used, which focuses on gaining information from participants who are "convenient" for the researchers to access. Later, in order to make groups of PWD and PWDcare participants homogenic purposive sample was used.

2.3 Research instrument

In order to examine the relational aspects of social interaction between family doctors and people with disabilities from the point of view of people with disabilities and their close ones, 10-items Likert-type scale "Relational aspects of social interaction between family doctors and people with disabilities" (RASI) were designed (see Table 2). While answering the questions respondents had to use a 5-point scale (1 – almost never true, 5 – almost always true). After the assessment of the reliability of the scale RASI, it was found that Cronbach's alpha coefficient was 0.926. It was calculated that pre-movement of one item from scale would increase the Cronbach's alpha coefficients slightly. In addition, there was not a single item which resolution of r/iit was less than 0.2. Considering what was mentioned above, it could be argued that the scale is characterized by internal coherence and is a suitable measurement instrument for relational aspects of social interaction between family doctors and people with disabilities.

2.4 Data analysis

Data analysis was performed using SPSS 22. Firstly, total RASI scale score was calculated. A Mann-Whitney test indicated that overall score of RASI was significantly higher in PWDcare ($Mdn = 3.90$) than in PWD ($Mdn = 3.70$), $U = 131904.5$, $Z = -1.967$, $p = .049$. Furthermore, the test indicated that only one item "If family doctor sees that patient is misunderstanding, he/she will ask his relatives to help patient with treatment and follow recommendations" was rated higher in PWDcare group (*Mean Rank* =526.06) than for PWD (*Mean Rank* = 444.59), $U = 98218.0$, $Z = -4.749$, $p < .001$ (Table 2). Therefore, it was decided to remove this item from the RASI scale and further analyze data of both respondents groups together.

Descriptive statistics provided a summary of RASI items data and Friedman test was performed to detect differences in the scale items scores. Moreover, the hierarchical multiple regression was used to determine whether relational aspects of social interaction between family doctors and people with disabilities can be predicted by: gender (men/women), the nature of disability (moderate/severe disability), disability acquisition (congenital/acquired disability), home care (requires constant maintenance/partial maintenance/can live without care) and living conditions (good/satisfactory/bad), types of disability. In this analysis, two blocks of independent variables were entered. The first block consisted of the variables of gender, the nature of disability, disability acquisition, home care and living conditions. The second block consisted of the variables identifying type of disability. To test for possible problems

with multicollinearity, collinearity diagnostics was performed. Tolerance values in all cases were between .71 and .99, the VIFs (variance inflation factor) were less than 4 (the maximum VIF was 1.528), The Durbin–Watson statistic was adequate (1.889). Correlated analysis of independent variables showed that the highest correlation was 0.267. This suggests that the multicollinearity assumption was not violated. The scatter plots have the (approximate) shapes of a rectangle, the scores are concentrated in the center (around the 0 point) and distributed in a rectangular pattern with no clustering or systematic pattern. This means that the assumption of homoscedasticity is met. Normality was examined using Normal P-P Plots. These plots indicate that points lay in a reasonably straight diagonal line from bottom left to top right. This suggests no major deviations from normality. To look for influential outliers in a set of predictor variables and identify the points that negatively affect the regression model, the Cook's distance was used. The Cook's distance value was .001. It suggests that there are no outliers in the regression models.

Table 2

Differences in RASI scale items between PWD and PWDcare

Relational aspects of social interaction between family doctors and people with disabilities	**Group**		**Test statistics**	
	PWD	**PWD care**	**Mann–Whitney U**	**Z**
	Mdn	*Mdn*		
Patient trusts the current family doctor	4	4	127930.5	-.076
Patient is satisfied with relationship with the family doctor	4	4	123199.0	-.301
Patient clearly understands what family doctor is telling	4	4	123739.0	-1.149
Family doctor listens carefully to stories about patient's condition	4	4	134221.5	-.156
Family doctor listens to stories about life and other things not directly related to patient's condition	4	4	122526.0	-.832
Family doctor expresses his/her compassion, warmth to patient	3	4	120203.5	-1.188
Family doctor tries to reassure patient when he is worried	4	4	126751.0	-.057
Family doctor is not showing his/her bad mood or fatigue	4	4	127414.5	-.247
In problematic situations, he/she tries to avoid conflict with patient	4	4	123499.0	-.114
If family doctor sees that patient is misunderstanding, he/she will ask patient's relatives to help with treatment and follow recommendations	4	4	98218.0	-4.749*

Note.*p < .05

3 Results

Evaluations of all RASI scale items ranged from 1 to 5. For 9 item median was 4, for item "Family doctor expresses his/her compassion, warmth to patient" median was 3. Friedman test indicated that items of RASI were evaluated statistically differently ($\chi^2_{(9)} = 522.987$, $df = 9$, $p < .001$). The Mean Ranks for items "Family doctor listens carefully to stories about patient's condition" (*Mean Rank* = 5.58), "Patient trusts family doctor" (*Mean Rank* = 5.56), "Patient clearly understands what family doctor is telling" (*Mean Rank* = 5.51) were higher and for items "Family doctor tries to reassure patient when he/she is worried" (*Mean Rank* = 4.54), "Family doctor listens to stories about life and other things not directly related to patient's condition" (*Mean Rank* = 4.19), "Family doctor expresses his/her compassion, warmth to patient" (*Mean Rank* = 3.93) were lower. Descriptive characteristics of RASI are summarized in Table 3.

Table 3

Descriptive characteristics of RASI

Relational aspects of social interaction between family doctors and people with disabilities	Mean Rank	M	SD	Mdn	1*	2*	3*	4*	5*
Family doctor listens carefully to stories about patient's condition	5.58	4.03	1.154	4	4.9%	6.2%	16.8%	25.1%	46.9%
Patient trusts family doctor	5.56	3.99	1.170	4	5.0%	7.9%	15.7%	26.5%	45.0%
Patient clearly understands what family doctor is telling	5.51	4.06	1.100	4	4.4%	4.1%	19.0%	25.9%	46.7%
Feeling satisfied with relationship with the family doctor	5.45	3.93	1.202	4	5.0%	7.9%	15.7%	26.5%	45.0%
In problematic situations, family doctor tries to avoid conflict with patient	5.33	3.91	1.171	4	6.2%	5.3%	20.5%	27.6%	40.4%
Family doctor is not showing his/her bad mood or fatigue	4.91	3.72	1.300	4	9.0%	9.3%	20.3%	23.1%	38.3%
Family doctor tries to reassure patient when he /she is worried	4.54	3.62	1.336	4	11.1%	9.5%	20.6%	24.3%	34.5%
Family doctor listens to stories about life and other things not directly related to patient's condition	4.19	3.44	1.416	4	14.0%	13.3%	19.5%	21.1%	32.0%
Family doctor expresses his/her compassion, warmth to patient	3.93	3.35	1.353	3	13.8%	12.3%	26.0%	21.4%	26.5%

Note* Respondents answers: 1 – almost never true, 5 – almost always true

Table 4 summarizes the multiple hierarchical linear regression analyses.

Table 4

Standardized (β) and nonstandardized (b) predictors of dependent variables and significance (p) in RASI

	RASI		
Independent variables	*b*	β	*p*
Step 1			
Gender	-.013	-.006	.867
Nature of disability	-.241	-.104	.011*
Disability acquisition	-.257	-.104	.003*
Home care	-.094	-.065	.114
Living conditions	-.312	-.142	.000*
Step 2			
Gender	.025	.011	.752
Nature of disability	-.247	-.107	.009*
Disability acquisition	-.188	-.076	.044*
Home care	-.040	-.027	.516
Living conditions	-.289	-.131	.000*
Mental and behavior disorders	.248	.092	.016*
Disease of the nervous system	.237	.093	.010*
Disease of the circulatory system	.181	.061	.093
Neoplasms	-.128	-.032	.382
Endocrine, nutritional, and metabolic disease	-.181	-.049	.171
Disease of the blood and blood-forming organs, and certain disorders involving immune system	-.135	-.028	.431
Disease of musculoskeletal system and connective tissue	-.067	-.019	.582
Disease of digestive system	-.510	-.073	.043*
Disease of eye and adnexa, ear and mastoid process	.044	.013	.721
R^2	Step 1 R^2 = .043		
	Step 2 R^2 = .071		

Four percent (4.3 %) of the variance in RASI was accounted for the variables in Block 1 (gender, the nature of disability, disability acquisition, home care and living conditions). Nature of disability, acquisition of disability and living conditions were significantly associated with an increase in RASI score, whereas gender and home care were not. Clinical characteristics such as moderate (vs severe) disability, congenital (vs acquired) disability and living in good (vs bad and satisfactory) conditions are associated with higher score on RASI. After Block 2 variables (type of disability)

had been added to the model, it was found that $R^2 = 0.071$, which means that a set of independent variables together accounted for 7.1 % of the variance in the RASI score. The variables in Block 2 uniquely contributed by 5.5% to the regression model; as such, the combination of disability type contributed substantially to the overall model. The Durbin–Watson $d = 1.889$, which is between the two critical values of $1.5 < d < 2.5$ and, therefore, we can assume that there is no first order linear auto-correlation in our multiple linear regression data. The results are statistically significant ($p < .001$, $F = 4.384$, $df = 14$). After types of disability were entered at step 2, it was revealed that nature of disability, acquisition of disability and living conditions, and tree types of disability (mental and behavior disorders, disease of the nervous system and disease of digestive system) were significantly associated with the RASI. Clinical characteristics such as moderate ($\beta = -.107$, $p = .009$), congenital ($\beta = -.076$, $p = .044$) disability, living in good conditions ($\beta = -.133$; $p < .001$), having disease of digestive system ($\beta = -.073$, $p = .043$), no mental and behavior disorders ($\beta = .091$, $p = .016$) or disease of the nervous system ($\beta = .093$, $p = .010$) are associated with higher score on RASI.

4 Discussion

This paper focuses on relational aspects of social interaction between family doctors and people with disabilities from the point of view of people with disabilities and their close ones. For the analysis several relational aspects were chosen: *patient is satisfied with relationship with family doctor, *patient trusts family doctor, *patient understands family doctor's talk, *family doctor listens to stories about life and other things not directly related to patient's condition, *family doctor listens carefully to stories about patient's condition, *family doctor expresses his/her compassion and warmth to patient, *family doctor tries to reassure patient when he/she is worried, *family doctor is not showing his/her bad mood or fatigue, *in problematic situations, family doctor tries to avoid conflict with patient.

According to responses to the answers, it can be concluded that Lithuanian family doctors maintain fairly good relationships with disabled patients. 72 percent of respondents confirmed that their family doctor listens to stories about the patients condition, 66.5 percent of them trust their family doctor, 72.6 percent understand their family doctors, 71.5 percent are satisfied with the relationship with their family doctor. 68 percent of respondents state that in problematic situations, the family doctor tries to avoid conflict with their patients, 61.4 percent – that the family doctor doesn't show his/her bad mood or fatigue, 58.8 percent – that their family doctor tries to reassure the patient when he /she is worried, 53.1 percent – that their family doctor listens to stories about the patient's life and other things not directly related to his/her condition.

It is interesting to note that the percent of trust in a family doctor is very close to the one stated in the Public Audit report – just a little more than 70 percent (Aukščiausioji audito institucija, 2018), however the latter percentage shows the satisfaction of all

patients with a family physician, and in our study case – only people with disabilities. This indicator is significantly lower than in a study, conducted more than a decade ago in which 94.2 percent of respondents said they trust their family doctor (Giedrikaitė, Misevičienė & Jakušovaitė, 2008). Whether this indicates a decline in trust in family physicians could only be determined by additional research.

Slightly less, but more than average the aspects of family doctors' compassion and warmth to patients with disabilities are expressed. A concern-worthy fact is that 26.1 percent of respondents do not sense or faintly sense the family doctors compassion and warmth, because empathy and compassion are foundational elements of the practice of medicine and vital cornerstones of high quality health care (Kelm, Womer, Walter & Feudtner, 2014, Lussier & Richard 2010), might positively affect patients' health (Attar & Chandramani, 2012). Family doctors' empathy might result in a faster recovery, feeling that they matter and even help patients to see meaning in life despite their pain or disability (Rakel, 2018), empathy is a powerful tool that health professionals can use to deliver care that is adapted to an individual's emotional, cognitive, and biological needs (Lussier & Richard 2010).

Research suggests that the relationship with a family practitioner is related to some types of disabilities: people with diseases of the digestive system maintain better relationships, people with diseases of the nervous system or mental/behavioral disorders retain worse relations. Moreover, research suggests that people having moderate, congenital issues, living in good conditions, maintain better relationships with their family physicians. These findings require further attention and explanation by the researchers.

The study revealed trends only confirm that the United Nations World Health organization rightly calls for "reform of health service models, focusing on the efficient provision of primary healthcare, in such manner the latter would be available, integrated, high-quality, community-based, people-oriented" (Five-year action plan for health employment and inclusive economic growth 2017–2021, 2018; World Health Organization. Global strategy on human resources for health: workforce 2030, 2016). This prompt is relevant to Lithuania's health system which lacks mechanisms which could be used to guarantee optimal service price and availability (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 21 p.). There is a large demand for a more effective public health policy, reformation of the healthcare system and investment in its improving (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 14 p.). Lithuania should take more measures to ensure the health of the population and quality healthcare while reducing inequalities in healthcare availability and quality (Sveikatos priežiūros sistemos vertinimas, 2019, 17 p).

5 Conclusion

Research suggests that from the point of view of people with disabilities and their close ones, some relational aspects of social interaction with family doctors are quite positively expressed. The majority of people with disabilities and their close ones are satisfied with their relationship with family doctors, they trust them, understand their talk. They admit that family doctors listen carefully to stories about patient's condition and things not directly related to the patient's condition, try to reassure the patient when they are worried, don't show their bad mood or fatigue, in problematic situations they try to avoid conflict with patients. Comparing to other relational aspects, family doctors' compassion and warmth to patients are slightly less expressed. In general, relational aspects are associated with some types of disabilities and some other characteristics, as living conditions, the nature of disability, disability acquisition. Relational aspects of social interaction with family doctors are expressed more positively by people having diseases of the digestive system, having moderate, congenital, living in good conditions, less positively – by people with diseases of the nervous system or mental/behavioral disorders. These findings, even though they cannot be directly compared with previous ones since prior research was not found tackling the same issues, can be considered as significant due to the fact that they provide the insight into the relational aspects of social interaction between family doctors and their patients with disabilities.

The data was collected using different approaches – paper questionnaires, online questionnaires. This resulted in nonprobability purposive sampling, leading to the limitations of generalizability of results.

When drawing the strategies for the changes in the effectiveness of functioning of the family doctor institution, it is purposeful to regard these research results and assume measures ensuring better social interaction between family doctors and patients, especially patients who are vulnerable because of their disability and face the family doctor institution more often due to more extensive needs for health services. Furthermore, the research results are very topical with regard to the training of family doctors – during university studies, it is important to emphasize the importance of social interaction, relationships and communication with patients.

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