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MASTER THESIS

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Supervisor: Dr. Cemil Yıldızcan

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LIST OF ABBREVIATIONS

AKP : Adalet ve Kalkınma Partisi (Justice and Development Party or JDP in English)
CHC : Community Health Center
CHP : Cumhuriyet Halk Partisi (Republican People's Party or RPP in English)
FHC : Family Health Center
HTP : Health Transformation Program
ISTAHED : İstanbul Aile Hekimleri Derneği (İstanbul Family Physicians' Association in English)
MoH : Ministry of Health

RESUME

Cette étude est un compte rendu qualitatif de la prestation des soins de santé primaires en Turquie et des médecins de famille en tant qu'acteurs principaux du système turc de soins de santé primaires. Il se concentre sur la transformation subjective qui s'est produite du côté des médecins de famille en Turquie avec l'introduction du PTS (Programme de Transformation de Santé) en 2003 et du régime de CSF (Centre de Santé Familiale) en 2005. Traiter le PTS comme une réforme néolibérale de la santé en parallèle avec d'autres réformes de la santé initiées ailleurs à partir d'environ du dernier quart du 20e siècle, l'étude vise à développer une image complète du processus de subjectivation néolibérale affectant les subjectivités quotidiennes des médecins de famille qui travaillent actuellement ou ont travaillé dans les centres de santé familiale après l'introduction du modèle en 2005. cela, il bénéficie d'un cadre théorique foucaldien, privilégiant une perspective micro du néolibéralisme sur les grands récits tels que l'approche marxiste ou institutionnaliste. Cependant, il essaie également de ne pas perdre le contact avec l'héritage institutionnel précédant le modèle FHC, dont les effets sont encore très visibles dans les déclarations des participants tout en détaillant leurs récits sur le fait d'être médecin de famille en Turquie actuellement.

L'axe théorique principal de l'étude s'appuie sur l'ouvrage influent de Pierre Dardot et Christian Laval intitulé « La nouvelle voie du monde : sur la société néolibérale » et plus précisément son avant-dernier chapitre « Fabriquer le sujet néolibéral ». Une élaboration du cadrage foucaldien du néolibéralisme dans ses célèbres conférences du Collège de France datant de 1978-79, intitulées « La naissance de la biopolitique ». Contrairement au reste de la littérature académique sur le néolibéralisme, la vision foucaldienne du sujet permet aux chercheurs de fournir un micro-focus sur les diverses manières dont le discours néolibéral est vécu par les sujets. Cette vision micro du néolibéralisme permet de mieux saisir le caractère contingent du néolibéralisme, différemment des macro-comptes le traitant comme l'imposition d'un discours hégémonique à travers tous les secteurs de la société comme une idéologie dominante. Dans le cadrage foucaldien du néolibéralisme, l'ethos directeur peut se résumer à « gouverner à distance » comme le formule Nikolas Rose (1999), permettant aux sujets d'agir à leurs frais d'une manière initialement inédite par l'État ou toute autre autorité, soit publique ou privée. La vision de Dardot et Laval du sujet néolibéral part de ce postulat et scrute les transformations subjectives marquant le virage néolibéral des expériences individuelles.

Refléter leur vision sur cette enquête a nécessité de mener un travail de terrain élaborant sur les identités professionnelles et les routines quotidiennes des professionnelles en soins de première ligne œuvrant dans un environnement où l'introduction du modèle de médecine familiale a complètement changé depuis 2005. À cet égard, une approche qualitative a été prioritaires depuis le tout début car une telle étude nécessitait un récit détaillé et méticuleusement documenté de leur existence professionnelle. Initialement, il était prévu comme une étude de terrain qualitative composée d'entretiens sur place avec les participants permettant également un certain

degré d'observation participante pour mieux saisir la nature de leur travail et comprendre leurs interactions quotidiennes avec les patients, les collègues et le personnel auxiliaire. Cependant, les limitations inévitables dictées par les conditions de la pandémie de COVID-19 en cours ont exclu cette option car les risques pour la santé posés par l'environnement d'un établissement de santé dans une telle période de temps ont conduit le chercheur à rechercher d'autres alternatives expliquant le choix de mener une enquête ethnographique online.

Si le compromis obligatoire concernant la conduite d'un travail de terrain sur le terrain a contrarié l'aspect participatif de l'étude, il a également enrichi la recherche d'une manière qui ne pouvait être stipulée au départ de cet effort. La réalisation d'entrevues en ligne via l'application Zoom a permis au chercheur de rencontrer à plusieurs reprises une image beaucoup plus détendue du médecin de famille dans le confort de sa maison et en compagnie de sa famille. Les entretiens onlines menés sur leur lieu de travail pendant leurs temps libres ont également permis un accès non-filtré à leurs interactions avec leur environnement car un entretien en ligne en cours n'était pas interprété comme un événement qui ne devrait pas être interrompu au cours d'une journée de travail routinière. Cela compensait, dans une certaine mesure, l'absence de présence physique dans l'environnement où l'entretien a été mené pour le chercheur et offrait également une observation plus riche à travers leurs environnements intimes permettant de voir comment leur vie privée recoupait leurs identités professionnelles.

Le premier contact avec le terrain a été obtenu via l'ISTAHED (Association des Médecins de Famille d'Istanbul) et l'échantillon a été généré par échantillonnage en boule de neige après ce point d'entrée. Sur la base des limites imposées par la pandémie, la planification était délicate car les participants avaient un horaire de travail très chargé, ce qui compliquait la recherche d'un créneau horaire approprié pour les entretiens. Cela explique en grande partie le calendrier empilé des entrevues qui ont été menées entre Février et Avril 2021. L'échantillon final qui en résulte est composé de vingt et un médecins de famille. Dix-huit d'entre eux travaillent actuellement à Istanbul. L'un d'eux est un ancien médecin de famille qui a travaillé à la fois à Istanbul et à Izmir et a récemment déménagé à Londres pour poursuivre une carrière médicale à l'étranger. Deux des participants travaillent actuellement à Diyarbakır. Douze des vingt et un participants sont des hommes et neuf d'entre eux sont des femmes. La majorité des participants ont entre 30 et 40 ans, tandis qu'une petite partie d'entre eux ont 40 ans ou plus. Même s'il n'y a pas de données officielles sur l'âge médian des médecins de famille ou le ratio hommes/femmes médecins servant dans les CSF, les conversations avec les participants ont amené le chercheur à croire que l'échantillon résultant représente une image équilibrée de la composition actuelle des professionnels des soins de santé primaires en Turquie.

L'étude qui en découle est organisée sous une division catégorique tripartite tout en couvrant les subjectivités transformatrices des médecins de famille. La première partie s'articule autour des diverses manières dont la subjectivation néolibérale des participants a été réalisée à travers une reconfiguration spatiale radicale de leur lieu de travail. Dans cette nouvelle formation spatiale appelée Centre de Santé Familiale (CSF). Introduisant un niveau élevé de responsabilisation pour les médecins de famille, ce nouveau format spatial les conduit à devenir cogestionnaires de leur espace

de travail conformément aux principes de l'approche du nouveau managérialisme. À cet égard, leurs responsabilités nouvellement acquises telles que le paiement de leur loyer, factures, dépenses personnelles, coûts salariaux, etc. ont été problématisées dans le contexte de la formation d'une identité professionnelle plus entrepreneuriale où une approche plus impliquée vers le métier de médecin a été à la fois adoptée et contestée par les participants à l'étude.

La seconde partie se concentre principalement sur l'évolution de leur régime de travail les transformant en ouvriers contractualisés à partir de leur statut traditionnel de fonctionnaire. Ce changement substantiel survenant au niveau de leur statut d'emploi s'est accompagné de l'introduction de mesures évaluatives strictes telles que le régime de performance négative et aussi de manière contradictoire avec leur statut de travailleur sous contrat, l'obligation d'employer un certain nombre de personnel auxiliaire proportionnellement à leur classification dans le spectre de CSF allant de E à A ; E étant le rang le plus bas et A le rang le plus élevé. La juxtaposition d'autres tendances de responsabilisation telles que les obligations liées à l'emploi et les mécanismes d'évaluation étendus tels que la quantification du rendement au travail crée un environnement dans lequel les participants se sentent confus quant à leur statut nouvellement acquis. Cette confusion est présentée comme un « dilemme employeur-employé » par une écrasante majorité des participants. Il s'agit à la fois d'une plus grande autonomie dans leurs professions accompagnée d'une pression menaçante fondée sur la stricte application du cadre d'évaluation actuel, menaçant à la fois leurs revenus et leur travail.

La troisième et dernière partie de l'étude problématise la dynamique médecin-malade dans le modèle FHC où les principes fondateurs de cette relation ont été radicalement redéfinis par l'État. Contrairement à l'ancien modèle où les médecins consultaient chaque patient dans un ordre de polyclinique, le nouveau modèle spatial dictait à chaque médecin de famille d'avoir une population enregistrée où l'autorité médicale du médecin de famille est tenue responsable. Dans ce nouvel arrangement régulant la dynamique médecin-patient, ce dernier groupe s'est vu accorder certains privilèges tels que le passage à un autre médecin de famille en cas d'insatisfaction des services médicaux fournis par son médecin actuel et le dépôt d'une plainte officielle pour le médecin. Ces nouveaux droits identifiés pour les patients ont entraîné un changement de pouvoir dramatique entre les médecins de famille et leur population, amenant les participants à se plaindre d'une perte de leur autorité médicale traditionnelle. Cette nouvelle tendance ouvre la voie à un changement discursif dans l'offre de soins de santé au niveau des soins de santé primaires, alors que la rhétorique de « la satisfaction du client » domine de plus en plus les récits des participants. Même lorsque les considérations éthiques se démarquent parmi d'autres préoccupations, cette tendance est tout à fait perceptible car la perte de leurs patients entraînerait une perte de revenu considérable et peut même menacer leur contrat de travail en cas de chute en dessous d'un certain seuil.

Le travail qui en résulte prétend atteindre au moins trois objectifs en contribuant aux études du néolibéralisme en Turquie. Tout d'abord, la manière dont l'étude a été menée présente un cadre général sur la manière de mettre en œuvre une analyse foucaldienne de la subjectivation néolibérale au contexte général de la

néolibéralisation en Turquie, et plus précisément de la néolibéralisation de la santé. Un autre objectif majeur de l'étude réside dans la manière dont elle problématise les subjectivités des médecins de famille. Les traiter comme des sujets actifs du néolibéralisme permet au chercheur d'éviter les tendances hégémoniques pour expliquer leurs conditions subjectives et de mieux saisir le caractère contingent du néolibéralisme dans un contexte local. Cet accent mis sur l'ancrage local des politiques néolibérales permet également de porter un regard plus nuancé tout en explorant les subjectivités quotidiennes des médecins de famille, car leurs comportements et attitudes sont significativement affectés par le cadre institutionnel hérité de l'ancien modèle de soins de santé primaires à divers égards.

ABSTRACT

This study is a qualitative account on primary healthcare provision in Turkey and family physicians as primary actors of Turkish Primary Healthcare system. It focuses on the subjective transformation that took place on the side of family physicians in Turkey with the introduction of HTP in 2003, and the FHC scheme in 2005. Treating the HTP as a neoliberal health reform in parallel with other health reforms initiated elsewhere starting roughly from the last quarter of 20th century, the study aims at developing a thorough picture of the neoliberal subjectification process affecting the everyday subjectivities of family physicians who are currently working or have worked in the Family Health Centers after the introduction of the model in 2005. Doing that, it benefits from a Foucauldian theoretical framework, privileging a micro perspective of neoliberalism over grand narratives such as Marxist or institutionalist approach. However, it also tries not to lose the contact with the institutional heritage preceding the FHC model, whose effects are still highly visible in the participants' statements while detailing their narratives on being a family physician in Turkey currently.

The main theoretical axis of the study is grounded on Pierre Dardot and Christian Laval's influential work called *"The New Way of the World: On Neoliberal Society"* and specifically its penultimate chapter *"Manufacturing the Neoliberal Subject"*. An elaboration of Foucauldian framing of neoliberalism in his famous Collège de France lectures dating back to 1978-79, called *"The Birth of Biopolitics"*. Differently than the rest of academic literature on neoliberalism, the Foucauldian take on the subject enables the researchers to provide a micro-focus for the diverse ways the neoliberal discourse is experienced by the subjects. This micro vision of neoliberalism ensures grasping the contingent character of neoliberalism more thoroughly, differently than the macro accounts treating it as the imposition of a hegemonic discourse through all sectors of the society as an all-encompassing ideology. In the Foucauldian framing of neoliberalism, the guiding ethos can be summarized as "governing at a distance" as is formulated by Nikolas Rose (1999), allowing the subjects to act their own expense in initially unprecedented fashion by the State or any other rule-making public or private entity. Dardot and Laval's vision of neoliberal subject departs from this premise and scrutinizes the subjective transformations marking the neoliberal shift on individuals' experiences.

Reflecting their vision on this inquiry necessitated conducting a field work elaborating on the professional identities and every day routines of primary health care professionals working in an environment where the introduction of family medicine model completely transformed since 2005. In that respect, a qualitative approach has been prioritized since the very beginning as such a study required a detailed and meticulously documented account of their professional existence. Initially, it was planned as a qualitative field study composed of onsite interviews with the participants allowing also a certain degree of participant observation to better grasp the nature of their work and understand their daily interactions with the patients, colleagues and auxiliary personnel. However, the unavoidable limitations dictated by the conditions of ongoing COVID-19 pandemic precluded this option as the health risks posed by the

environment of an health institution in such a period of time channeled the researcher to look for other alternatives explaining the choice for conducting an online ethnography.

Although the compulsory compromise regarding to conduct an onsite field work thwarted the participatory aspect of the study, it also enriched the research in ways that could not be stipulated at the outset of this effort. Conducting online interviews via Zoom app enabled the researcher to encounter a much more relaxed image of family physician in the comfort of their houses and in the company of their families on several occasions. The online interviews conducted in their workplaces during their spare times also granted a more unfiltered access to their interactions with their environment as an ongoing online interview was not interpreted as an event that should not be interrupted in the course of a routine day at work. This compensated, to a certain degree, for not being physically present in the environment where the interview has been conducted for the researcher and also provided a richer observation through their intimate environments allowing to see how their private lives intersect with their professional identities.

The first contact with the field has been obtained through ISTAHED (Istanbul Family Physicians' Association) and the sample has been generated through snowball sampling following this entry point. Based upon the limitations set by the pandemic, the scheduling was tricky as the participants had a highly loaded work schedule, complicating to find a suitable time slot for the interviews. This largely explains the stacked schedule for the interviews that has been conducted between February and April 2021. The resulting final sample consists of twenty-one family physicians. Eighteen of them are currently working in Istanbul. One of them is a former family physician who has worked both in Istanbul and Izmir and recently moved to London to pursue a medical career abroad. Two of the participants are currently working in Diyarbakır. Twelve out of twenty-one participants are male and nine of them are female. The majority of the participants are aged between 30 and 40 while a smaller portion of them are 40 or above. Even though, there is no official data on the median age of the family physicians or the ratio of male and female medical doctors serving on the FHCs, the conversations with the participants led the researcher to believe that the resultant sample represents a balanced picture of the current composition of primary health care professionals in Turkey.

The consequent study is organized under a tripartite categorical division while covering the transforming subjectivities of family physicians. The first part revolves around the diverse ways where the neoliberal subjectification of the participants has been achieved through a radical spatial reconfiguration of their workplace. In this new spatial formation called the Family Health Center (FHC). Introducing an extensive level of responsibilization for the family physicians, this novel spatial format channels them to become co-managers of their work space in line with the principles of the new-managerialism approach. In that respect, their newly acquired liabilities such as paying their rent, bills, personal costs, employment costs and so forth have been problematized in the context of the formation of a more entrepreneurial professional identity where a more involved approach towards being a medical doctor has been both adopted and contested yet at the same time by the participants of the study.

The second part mainly focuses on their changing labor regime transforming them into contractualized laborers from their traditional civil servant status. This substantial change occurring on the level of their employment status has been accompanied by the introduction of strict evaluative measures such as negative performance scheme and also contradictorily with their contracted worker status, obligation to employ a certain amount of auxiliary personnel in proportion to their respective classification in the FHC spectrum ranging from E to A; E being the lowest and A the highest rank. The juxtaposition of further responsibilizing tendencies such as employment liabilities and the extensive evaluative mechanisms such as the quantification of work performance creates an environment where the participants feel confused about their newly earned status. This confusion is framed as *"employer-employee dilemma"* by an overwhelming majority of the participants; experiencing both a higher level of autonomy in their professions accompanied with a threatening pressure based upon the strict implementation of the current evaluative framework, threatening both their income and work.

The third and final part of the study problematizes the doctor-patient dynamic in the FHC model where the founding principles of this relationship has been radically redefined by the State. Unlike the former model where medical doctors consulted every incoming patient in a polyclinic order, the novel spatial model dictated each family physician to have a registered population where the medical authority of the family physician is held liable. In that novel arrangement regulating the doctor-patient dynamics, the latter group has been granted some privileges such as switching to another family physician in case of an unsatisfaction with the medical services provided by one's current doctor and filing an official complaint for the registered medical doctor. These new rights identified for the patients resulted in a dramatic power shift between family physicians and their population, leading the participants to complain about a significant loss of their traditional medical authority. This novel tendency paves the way to a discursive shift in the healthcare provision on primary healthcare level, as "the customer satisfaction" rhetoric increasingly dominate the narratives of the participants. Even when the ethical considerations stand out amongst other concerns, this tendency is quite discernible as losing their patients would result in a considerable loss of income and may even threaten their labor contract in case they fall below a certain threshold.

The resultant work claims to achieve at least three objectives in contributing to the studies of neoliberalism in Turkey. First of all, the way the study has been conducted presents a general framework on how to implement a Foucauldian analysis of neoliberal subjectification to the general context of neoliberalization in Turkey, and the neoliberalization of health to be more specific. Another major aim of the study lies in the way it problematizes the subjectivities of the family physicians. Treating them as active subjects of neoliberalism enables the researcher to avoid the hegemonic tendencies to explain their subjective conditions and to better grasp the contingent character of neoliberalism in a local setting. This emphasis on the local embeddedness of neoliberal policies also allows for a more nuanced look while delving into the everyday subjectivities of the family physicians as their behavior and attitudes are significantly affected by the inherited institutional framework of the former primary

healthcare model in various respects, highlighting the benefits of employing a Foucauldian perspective in a more accentuated manner.

ÖZET

Bu çalışma, Türkiye'de birinci basamak sağlık hizmeti sunumuna ve birinci basamak sağlık uygulamalarının birincil aktörleri olan aile hekimlerine ilişkin nitel bir saha araştırmasının ürünüdür. 2003'te Sağlıkta Dönüşüm Programının ve onu takiben 2005'te Aile Sağlığı Merkezi modelinin devreye girmesiyle Türkiye'de aile hekimleri nezdinde meydana gelen öznellik dönüşümüne odaklanıyor. SDP'nin, dünyanın çeşitli ülkelerinde 20. yüzyılın kabaca son çeyreğinden itibaren devreye alınan diğer sağlık reformlarına paralel olarak neoliberal bir sağlık reformu olarak ele alındığı bu çalışma, günümüzde halen aile hekimi olarak hizmet vermekte olan veya bir dönem aile hekimliği yapmış doktorların gündelik yaşamlarını ve mesleki kimliklerini radikal bir biçimde etkileyen neoliberal öznelleştirme sürecinin kapsamlı bir resmini sunmayı amaçlıyor. Bunu yaparken ise, Marksist veya kurumsalcı yaklaşımlar gibi büyük anlatıların neoliberalizmi hegemonik bir ideoloji ve hayatın her alanını kapsayan ve özneleri beraberinde getirdiği dönüşümlerin edilgen aktörleri olarak konumlandıran bakışından ziyade, bireylerin öznellik alanları ve faillik potansiyellerini tartışmaya açan Foucaultcu bir teorik çerçeveden yararlanıyor. Bununla birlikte, çalışmanın katılımcılarının anlatılarında etkileri halen oldukça belirgin olan ve ASM modelini önceleyen Sağlık Ocağı modelinin kurumsal mirasının günümüzdeki yansımaları ve halefiyle olan temasını da kaybetmemeye çalışıyor. Bu sayede ortaya çıkan çalışmanın tek boyutlu bir neoliberal öznellik anlatısından ziyade kronolojik olarak birbirinin üzerine eklemlenen kurumsal, bürokratik, mekânsal süreçlerin öznellik süreçleri üzerindeki kompleks etkilerini mümkün olduğunca yakalamaya gayret ediyor.

Çalışmanın ana teorik ekseni, Pierre Dardot ve Christian Laval'ın 2014 tarihinde yayımlanan "Dünyanın Yeni Aklı: Neoliberalizm Üzerine Toplumsal bir Deneme" adlı çalışmalarına ve özellikle de eserin sondan bir önceki bölümü olan ve "Neoliberal Öznenin İmali" adını taşıyan bölümü etrafında biçimlenmektedir. Esinini ve bağlı bulunduğu kuramsal çerçeveyi Michel Foucault'nun 1978-79 yıllarına tarihlenen ve daha sonra kitap halinde de yayımlanan "Biyopolitikanın Doğuşu" adlı ünlü Collège de France derslerinden alan ve alana getirdiği yeniliğinin Foucaultcu bir neoliberalizm temellendirmesinden yola çıkılarak neoliberal öznellik süreçlerinin günümüz toplumsal dinamikleri çerçevesinde yorumlanması olarak tanımlayabileceğimiz eserde, neoliberalizm temelinden yola çıkarak çeşitlenen akademik literatürün geri kalanından farklı olarak, konunun Foucaultcu perspektiften ele alınışı, araştırmacıların neoliberal söylemin gündelik hayatta kendini öznellik süreçleri üzerinden nasıl yeniden ürettiğini ve bunu yaparken de öznelerin dönüşümüne ve kendilerini dönüştürmelerine ne gibi olanaklar sunduğunu anlayabilecek mikro odakların keşfine olanak tanıyor. Neoliberalizmin bu mikro perspektiften yeniden ele alınması, onun olumsal karakterini; neoliberalizmin toplumun tüm kesimlerini sınırsız ve aralıksız olarak etkisi altına olan hegemonik bir ideoloji olduğu ön kabulüyle yola çıkan makro perspektiflere nazaran çok daha iyi kavramaya olanak tanır. Neoliberalizmin Foucaultcu çerçevelemesinde, kurucu prensip yönetimsel bir çerçeveden ele alındığında Nikolas Rose (1999) tarafından da formüle edildiği gibi "uzaktan yönetmek" olarak özetlenebilir ve öznelerin Devlet veya başka herhangi bir kural koyucu kurum veya kuruluşun tek taraflı boyunduruğu altında bulunduğu ve pasif özneler olarak konumlandırıldıkları bir tahayyülün ötesinde, kendi kendilerini idare

eden ve onlara tanınan seçme özgürlüğünün sınırları çerçevesinde, her zaman öngörülemeyecek sonuçlar da üretmeye muktedir özneler olarak konumlandırır. Dardot ve Laval'ın, neoliberal özne vizyonu bu kurucu öncülden yola çıkar ve bireylerin gündelik deneyimlerinde neoliberal değişim ve dönüşümün izlerine işaret eden öznel dışavurumları bu literatürle olan bağlantısını koparmadan detaylı bir biçimde inceler.

Ortaya çıkan ürünü bu metinden ve ona kaynaklık eden literatürden yola çıkarak kurgulamak, çalışmayı 2005 yılında hayata geçen aile hekimliği modeliyle birlikte radikal olarak dönüşen bir kurumsal ve mekânsal bir yapıda hizmet veren birinci basamak sağlık çalışanlarının mesleki kimliklerini ve günlük rutinleri bağlamında ele alan bir saha çalışması olarak yapılandırma zorunluluğunu doğurmuştur. Bu çerçevede çalışmanın genelinde nitel bir yöntem benimsenmiştir. En başından beri gündelik deneyimlerin aktarımına ve mesleki tecrübelerin birincil tanıklıklar aracılığıyla dillendirmesine öncelik veren bir çalışma, aile hekimlerinin kurumsal ve mesleki kimliklerinin ötesine geçerek bir birey olarak bu yeni modeli nasıl deneyimlediklerini ayrıntılı ve titizlikle belgelendiren bir çaba gerektiriyordu. Bu nedenle başlangıçta, katılımcıların iş yaşamlarının doğasını daha iyi kavramak ve hastaları, meslektaşları ve yardımcı personel ile günlük etkileşimlerini neoliberal öznellik inşası çerçevesinde anlamlandırabilmek için belirli bir düzeyde katılımcı gözlemine de yer veren ve katılımcılarla yerinde görüşmelerden oluşan nitel bir saha çalışması olarak planlandı. Ne var ki, halen endişe verici bir biçimde varlığını sürdüren COVID-19 pandemisinin koşulları tarafından dikte edilen kaçınılmaz sınırlamalar, bir sağlık kuruluşunda bu çalışmayı gerçekleştirmenin bu zaman zarfında teşkil ettiği ve hem araştırmacı hem de katılımcılar yönünde mevcut olası sağlık riskleriyle birlikte değerlendirildiğinde, bu seçeneğin saf dışı kalmasına yol açtı ve nu koşullar altında araştırmayı olabildiğince sağlıklı bir biçimde ilerletmeye olanak tanıyan başka alternatiflere yönelmeyi zorunlu kıldı. Bu süreçte benimsenen online etnografi metodunun tercih edilmesinin altında yatan ana motivasyon kısaca bu biçimde özetlenebilir.

Yerinde saha çalışması yapılmasına yönelik zorunlu taviz, çalışmanın katılımcı gözleme yer vermeyi hedef edinen başlangıç amaçlarından bir miktar sapmaya yol açmış olsa da araştırmayı başlangıçta öngörülmeyen yönlerden zenginleştirmiştir. Zoom uygulaması üzerinden online görüşmeler yapılarak ilerleyen çalışma, araştırmacının evlerinin rahatlığında ve ailelerinin eşliğinde çok daha gündelik hallerinde bir aile hekimi görüntüsüyle karşılaşmasını mümkün kılmıştır. Bunun haricinde aile hekimleriyle boş vakitlerinde işyerlerinde gerçekleştirilen online görüşmeler, araştırmacının salt fiziki varlığının yaratabileceği iş yerindeki rutin bir günün akışının kesintiye uğratabilecek pratik durumun yokluğundan dolayı, aile hekimlerinin çevreleriyle gün içindeki etkileşimlerine daha filtresiz bir erişim imkanı sağlamıştır. Bu durum, araştırmacı için görüşmenin yapıldığı ortamda katılımcı gözlemci sıfatıyla mevcut bulunamayışının yol açabileceği olumsuzlukları belli bir dereceye kadar telafi etme imkanı sunarken ayrıca aile hekimlerinin iş yerlerindeki gündelik hayatlarına daha dolaysız bir erişimi mümkün kılmasından ötürü de araştırmaya artı bir zenginlik olarak yansımıştır.

Saha ile ilk temas İSTAHED (İstanbul Aile Hekimleri Derneği) aracılığıyla sağlanmış ve bu giriş noktasının ardından kartopu örnekleme metoduyla örneklem

oluşturulmuştur. Pandemi tarafından dayatılan sınırlamalar, katılımcıların oldukça yüklü çalışma programlarıyla birlikte değerlendirildiğinde, araştırmaya temel teşkil eden mülakatlar için uygun bir zaman aralığı bulmak çalışma sürecinde karşılaşılan en temel pratik sorun olmuştur denilebilir. Bu, 2021 yılının Şubat ve Nisan ayları arasında tamamlanan ve oldukça dar bir zaman sıkıştığı söylenebilecek görüşme takvimini büyük ölçüde açıklıyor. Sürecin sonunda ortaya çıkan nihai örneklem, yirmi bir aile hekiminden oluşuyor. Bunların on sekizi hali hazırda İstanbul'da çalışmaktayken, katılımcılardan bir tanesi, geçmişte hem İstanbul'da hem de İzmir'de muhtelif ASM'lerde çalışmış ve yakın zamanda mesleki kariyerini yurt dışında sürdürebilmek için Londra'ya taşınmış eski bir aile hekimidir. Katılımcılardan ikisiyse Diyarbakır'da aile hekimi olarak çalışmaktadır. Yirmi bir katılımcının on ikisi erkek, dokuzu kadın aile hekimlerinden oluşmaktadır. Katılımcıların çoğunluğu 30-40 yaşları arasındayken, daha küçük bir kısmı ise 40 yaş ve üzerindedir. Aile hekimlerinin ortalama yaşı veya ASM'lerde görev yapan kadın ve erkek hekimlerin oranı hakkında elde resmi bir veri bulunmamasına rağmen, katılımcılarla yapılan görüşmeler esnasında edinilen bilgiler, ortaya çıkan örneklemin Türkiye'de birinci basamak sağlık profesyonellerinin mevcut demografik kompozisyonunun dengeli bir yansıması olduğu konusunda ikna edici görünmektedir. Yine de, hem Diyarbakır'daki iki tekil örnek haricinde tümüyle İstanbul'da çalışan katılımcılarla oluşturulan bir örneklem olması, hem de katılımcı sayısının darlığından ötürü ortaya çıkan sonuçların ülke genelindeki aile hekimlerinin genel özelliklerini yansıtacak biçimde kapsayıcı olduğunu düşünmek hatalı olacaktır. Zaten söz konusu çalışma nitel bir saha araştırmasına dayandığından böyle bir iddiası da bulunmamaktadır.

Ortaya çıkan üründe, aile hekimlerinin dönüşen öznelliklerini mercek altına alırken, sonuçlarını üçlü bir kategorik bölümleme altında düzenlendiği görülebilir. Teorik giriş bölümünü takiben sahanın sonuçlarını ele alan ilk bölüm, katılımcıların neoliberal öznelliklerinin inşasını, çalışma mekanlarının ASM olarak adlandırılan bu yeni modelde radikal bir mekânsal yeniden yapılandırılmaya tabi tutulması üzerinden nasıl biçimlendirildiği sorusu etrafında ele alıyor. Aile hekimlerine daha önceki Sağlık Ocağı modelinde var olmayan ölçüde kapsamlı sorumluluklar yükleyen bu yeni mekânsal format, onları yeni kamu yönetimi yaklaşımı ilkeleri doğrultusunda çalışma alanlarının eş yöneticileri olmaya yönlendiriyor ve bunun için teşvik ediyor. Bu bağlamda kiralarını, faturalarını, kişisel giderlerini ve istihdam giderlerini kendilerine verilen ve enflasyon oranına göre yıllık olarak güncellenen aylık bir cari giderden karşılayan aile hekimlerinin sahip oldukları bu yeni yükümlülükler, tıp mesleğinin sınırlarını geleneksel alanın dışına doğru esneterek daha girişimci ve aktif bir hekim performansını zorunlu kılan bir profesyonel kimliğin oluşumunu da zorunlu kılıyor. Katılımcılarla yapılan görüşmelerde yeni edinilen mesleki sorumluklar mekânsallık üzerinden tartışmaya açılıyor ve aile hekimlerinin mesleklerinin bu yeni tanımı karşısında nasıl konumlandıkları irdeleniyor.

İkinci bölüme geçildiğindeyse, onları geleneksel memur statülerinden çıkararak sözleşmeli işçilere dönüştüren yeni çalışma rejimine ve bunun mesleklerinin icrasında yarattığı etkilere odaklanılıyor. İstihdam koşullarında meydana gelen bu hukuki temelli değişikliğe, negatif performans yöntemi gibi sıkı değerlendirme önlemlerinin eklenmesi ve buna karşılık mevcut sözleşmeli işçi statüleriyle çelişkili olarak, bağlı bulundukları sınıflandırma kriterline göre belirli miktarda yardımcı personel istihdam

etme zorunluluğun eşlik etmesi gibi kağıt üzerinde birbiriyle uyuşmayan uygulamaların neoliberal öznellik bağlamında aile hekimlerinin mesleklerini kavrayışını nasıl etkilediği tartışılıyor. İşveren yükümlülüğü gibi aile hekimlerinin omzuna daha fazla sorumluluk yükleyen bir uygulamanın iş performansının negatif performans gibi nicel yöntemlerle ölçülmesi gibi yeni değerlendirme mekanizmalarıyla yan yana gelişinin, katılımcıların mevcut durumları konusunda kafa karışıklığına yol açan bir ortamın oluşmasına zemin oluşturduğunun gözlemlendiği görüşmelerde bu durum, katılımcıların önemli bir çoğunluğu tarafından "işveren-çalışan ikilemi" olarak çerçevelenmektedir. Buna göre katılımcılar bir yandan çalışacakları personeli kendilerinin istihdam etmesine olanak veren ve yardımcı personelin doğrudan onlara bağlı olarak tanımlandıkları bu yeni durumun sağlık hizmet sunucuları olarak mesleki özerkliklerini perçinleyen bir ortam yarattığını ifade ederken, diğer yandan da doğrudan gelirlerini ve hatta mesleklerini tehdit eden negatif performans ölçümü gibi değerlendirme mekanizmaların getirdiği baskı ortamıyla birlikte bu özerkliğin ne kadar uçucu olduğunun altını çiziyorlar.

Çalışmanın üçüncü ve son bölümündeyse, ASM modeline geçişle beraber devlet tarafından bütünüyle yeniden tanımlanan doktor-hasta ilişkilerinin farklılaşan dinamikleri ve bunun öznel sonuçları sorunsallaştırılıyor. Sağlık Ocağı modelinde gelen her hastaya rastgele bir poliklinik düzeni içinde hizmet verilen eski yöntemden farklı olarak, mevcut yeni mekânsal model, her aile hekiminin kendisine kayıtlı hastalardan oluşan stabil bir popülasyona hizmet vermesi prensibi etrafında örgütleniyor. Doktor-hasta ilişkilerini bütünüyle farklı bir perspektiften ele alan bu yeni düzenlemede, hastalara mevcut aile hekiminin sunduğu sağlık hizmetinden memnun kalmaması durumunda başka bir hekime kaydolma ve kayıtlı bulunduğu hekim hakkında şikayette bulunma gibi bazı yeni haklar tanındığı görülüyor. Hastalara tanımlanan yeni haklar, aile hekimleri ve nüfusları arasındaki güç dengelerinde dramatik bir eksen kaymasına neden olurken, bu durum katılımcıların anlatılarında tıbbi otoritelerini önemli ölçüde yitirmekten kaynaklanan önemli bir memnuniyetsizlik biçiminde kendini gösteriyor. Doktor-hasta ilişkilerinde son yıllarda giderek daha da belirgin hale gelen bu trend, "müşteri memnuniyeti" retoriğinin katılımcıların anlatılarındaki ağırlığını açıklarken, aynı zamanda birinci basamak sağlık hizmeti sunumunda söylem bazında pazar ilkelerinin daha baskın hale geldiği önemli bir dönüşüme işaret ediyor. Her ne kadar bu durumun çerçevelenmesinde çoğu zaman etik kaygıların ön plana çıktığı gözlemlense de, olası bir iş kaybının yarattığı korku ya da popülasyonlarındaki ciddi bir düşüşün gelir seviyelerinde yol açacağı hatırı sayılır düşüşten duyulan endişenin, katılımcıların birçoğunu hastaların taleplerine karşılık vermek konusunda mesleki prensiplerini esnetmeye yöneltebildiği görülebiliyor.

Sonuç olarak ortaya çıkan ürünün, Türkiye'deki neoliberalizm çalışmalarına üç farklı aşamada katkı sunduğu söylenebilir. İlk olarak, Türkiye akademisinde neoliberalizm çalışmaları alanında var olan önemli bir boşluğu doldurmaya yönelik öncü bir çaba olması nedeniyle, biçim ve içerik olarak bir örnek teşkil ettiği iddia edilebilir. Her ne kadar neoliberalizmi öznellik inşası temelinde ele alan çalışmaların Türkiye özelindeki sınırlılığı araştırmanın yazım aşamasında belli zorluklara yol açmışsa da, bu eksiklik uluslararası çalışmaları temel alan bir yaklaşımla aşılmaya çalışılmış ve yazma sürecinde belli bir yaratıcılık ve esnekliğe de alan tanımıştır.

Çalışmanın yürütülme şeklinin ve üzerinde biçimlendiği etnografik temelin, genel olarak Türkiye'deki neoliberal öznellik süreçlerinin ve spesifik bir bağlamda sağlığın neoliberalleşmisinin Foucaultcu bir bağlamda ele alınırken nasıl uygulanacağına dair genel bir çerçeve sunduğu düşünülmektedir. Çalışmanın bir diğer önemli sonucu ise aile hekimlerinin, ASM modeli bağlamında dönüşen öznelliklerinin daha önce olmadığı bir biçimde sorunsallaştırma fırsatı sunmasıdır. Onları sağlık alanında politika düzeyinde gerçekleşen neoliberal dönüşümün sahadaki izdüşümü olan aktif özneleri olarak konumlandırmak, araştırmacının aile hekimlerinin öznel koşullarını açıklamak için neoliberalizm çalışmaları alanında özellikle ülkede son derece yaygın olan hegemonik eğilimlerden kaçınmasını mümkün kılar. Bu yaklaşım aynı zamanda Türkiye'de sağlık alanındaki neoliberalleşmenin, küresel düzeydeki trendlerin doğrudan yerel bağlama yansıması yönündeki kavrayıştan sıyrılarak ülkeye özel koşullar bağlamında neoliberalizmin olumsal karakterini daha iyi kavrama fırsatı sunar. Neoliberal politikaların boş bir düzlemde ve neredeyse bir vakum içerisinde kendini var etmesi gibi bir ön kabulü reddeden bu tutum, mevcut politikaların üzerine inşa edildiği kurumsal mirasın günümüzdeki yansımalarını aile hekimlerinin anlatıları temelinde biçimlenen söylem üzerinden yakalamayı mümkün kılmaktadır. ASM modeli ve beraberinde gelen aile hekimliği uygulaması her ne kadar birinci basamak sağlık hizmeti sunumunda 40 yıllık bir geçmişe dayanan kurumsal gelenekten ve Sağlık Ocağı sisteminden radikal bir kopuşu işaret etse de, devralınan mirasın hem aile hekimlerinin öznelliklerini biçimlendirme hem de neoliberal öznellik perspektifinden bu mirası yeniden yorumlamalarına olan etkisi düşünüldüğünde, çalışmayı Foucaultcu bir perspektif temelinde yapılandırmanın avantajları da daha belirgin bir biçimde ortaya konmuş olacaktır.

-1-
INTRODUCTION

1.1. A Personal Background for the Study

When I first arrived at college, there was one specific debate topic dominating heated discussions at the campus. It was roughly a year after the Great Recession of 2008, and the main subject in every corner was neoliberalism and its so-called crisis. As a young political science student who wanted to be a part of the conversation, I started wondering what neoliberalism is really about and to read about the subject, which marks roughly the beginning of my scholarly attention towards the issue.

As I dug deeper, I also realized how deep the impact of neoliberalism lies in Turkey starting from the early 1980s and how its pace has accelerated in every milieu of our collective life as a society and our subjective existence as individuals, especially after the AKP's ascension to power in 2002. This study, whose traces can be tracked back into that period, focuses on the impact of neoliberalization in primary healthcare professionals' daily and professional lives. It can be interpreted as the culmination of my curiosity on neoliberalism, first as a young college student and then as a novice researcher.

The reason that I privilege the "neoliberalization of health" over other areas that are related to the subject can be found in my personal history. As an individual who has disabled relatives in his family, I had the chance to observe both the advantages of having proper access to the healthcare system in terms of treatment and medication and the negative consequences and suffering caused by not having any health coverage and being deprived of even a minimal amount of medical care whatsoever.

It was a transformative experience for me to witness the stark contrast between the two situations while growing up. It urged me to interpret access to adequate healthcare coverage, at least on a minimum basis, as an essential human right that

needs to be fulfilled at any cost. All in all, my personal experiences while growing up and my academic engagement together determined the course of my uninformed curiosity for neoliberalism, brought me through the specific intersection of healthcare and neoliberalism, and built up to this work that delves into uncovering the subjective effects of neoliberalism on health care workers.

When considering that this is an MA thesis, the study does not aim for greater heights out of its reach and scope. It has a clear intention in documenting primary healthcare workers' subjective experiences of neoliberalism related to the qualitative change of the nature of their work following the accelerating neoliberalization of healthcare in Turkey with the implementation of the Health Transformation Program (HTP) in 2003 and especially after the introduction of Family Health Centers(FHC) as central pillars of primary healthcare provision in 2006.

This field study, qualitative in nature, also aims to present a particular interpretation of neoliberalism that favors agency over the structure and allows the subjective experience to be brought into the light and reviewed within social sciences' borders. Informed by my unbridled and lifelong interest in listening to personal narratives and trying to make sense of them in a scholarly context, the Foucauldian theory of governmentality gave me the much-needed impetus that I have been looking for in my academic interests and this study particularly.

My dearest expectation for this modest contribution to neoliberalism studies is that it constitutes a robust effort in a primarily neglected research area so far by social science in Turkey, and it hopefully triggers the scholarly debate and further research in the field. I also wish to render primary healthcare workers' voices and experiences visible in these challenging times, as they are battling with a global pandemic on the frontline. From that point forward, the following text is yours to read, comment, and criticize.

1.2. Making "Neoliberalism" Work as a Concept

These are troublesome times for all of us. We are living amid a deadly pandemic. The looming shadow of the COVID-19 sanitary crisis and the subsequent global economic crisis unseated all of our conventions and left us with the immediacy of generating a quick and satisfactory response in the middle of this tumultuous set of events that are likely to result in a seismic paradigm shift in every aspect of our lives for the foreseeable future. However, no theories or explanations tackling this complexity have yet to prevail over the others so far.

Nevertheless, we had one magic word that held the key for most of our critical accounts until very recently: "Neoliberalism." In its heyday, it was flooding the academic writings of innumerable social scientists, dominating the everyday conversations of numerous people, invading the columns of journals and debates on media, and speculated on and talked about ceaselessly as a term. When Peck and Tickell (2017) wrote, "neoliberalism seems to be everywhere," not only they were making a case for the far-reaching character of neoliberalism as a political-economic project affecting nearly every corner of the world in varying degrees, but they were emphasizing this literal dominance of the term as an explanatory tool in social sciences.

Even though the meaning of neoliberalism, its history, and its rise to prominence has been widely discussed, one of the different conceptualization efforts has yet to stand out as the dominant explanation. One thing is for sure, though. The reach and scope of the term's various iterations have become so pervasive that the "what" and "how" of the concept became growingly vaguer today. We can observe that some authors have even pondered on the efficiency and operational capacity of the term. This can partly be ascribed to the own success of "neoliberalism" as it is one of the most widely circulated concepts of the critical literature in social sciences. In an attempt to give an extensive list of varying contexts for which the term "neoliberal" has been used, Clarke (2008, p.138) identifies at least forty-one different iterations where it has been qualified as an adjective. Flew (2014) also underlines quite

illustratively an abundant number of examples where neoliberalism has been employed as the main framework with a cautionary tone. As an immediate outcome of the term's overuse, neoliberalism is now widely considered controversial, incoherent, and crisis-ridden as a concept, even by its fiercest advocates.

"'Critics describe it as 'an oft-invoked but ill-defined concept' (Mudge, 2008, p.703), '*that is omnipresent and promiscuous'*(Clarke, 2008, p.135), whose meaning *'seems to alter its shape from paper to paper'* (Castree, 2006, p.1) such that *'what it stands for and what it explains is both confused and confusing'* (Turner, 2008, p.2). It seems to suffer from *'a perplexing mix of overreach, and underspecification'* (Brenner et al., 2010, p.2) and is used as *'a constant master category that can be used both to understand and explain all manner of political programs across a wide variety of settings'* (Rose et al., 2006, p.97)" (cited in Vanugopal, 2015, p.166).

When we look at all those critical accounts of the term, what we encounter may seem a bleak picture at first. However, what is essential for conducting research whose main objective is tackling neoliberalism in a specific context such as ours is to specify and elaborate the concept as much, underline it as boldly as possible, and remain loyal to the theoretical framework is established in the very beginning. To achieve that adequately, what I deem to be indispensable is to clarify how neoliberalism is defined for this study, and that requires a brief overview of the competing definitions of neoliberalism in the first place.

1.3. "N"eoliberalism or "n"eoliberalism?

Much of the fuss going on around giving a prevailing definition of neoliberalism can be ground upon a simple question formulated by Stephen J. Collier when he asked, *"Should neoliberalism be analyzed as a 'big Leviathan'- a macrostructure or explanatory background against which other things are understood? Or should we rather analyze neoliberalism as though it were the same size as other things, and race its associations with them?"* (Collier, 2012, p.186). Aihwa Ong, a notable scholar of governmentality theory, answered that in favor of the

second option stating *"there is not one big-N neoliberalism but an indefinite number of small-n neoliberalisms born of the ongoing hybridization of neoliberal practices and ideas with local conditions and forms"* (Wacquant, 2012, p.70).

However, those who favored the first option constituted the majority until very recently, and the field of neoliberalism studies has been dominated by a monolithic definition of neoliberalism whose roots can be traced back to neo-Marxist literature and Gramscian reading of Marx, where the concept of hegemony has been privileged over others (see Laclau and Mouffe, 2014; Duménil and Levy, 2004, 2011; Harvey 2005, 2007; Saad-Filho and Johnston, 2005; Peet, 2007; Hall, 2011; Van Apeldoorn and Overbeek, 2012; Cahill, 2014). As one of the fiercest defenders of the Marxist interpretation of the term, Perry Anderson (2000, p.17) claims neoliberalism to be *"the most successful ideology in world history."* Even though it may not sound as assertive as Anderson does at first, David Harvey (2005), as one of the quintessential representatives of that camp, puts that neoliberalism can be interpreted as a hegemonic ideology inexorably tied to the restoration of class power and sets the general framework for this theoretical tradition. This idea is also supported in Duménil and Levy (2004) writings as they remark the collapsing wealth of the top 1 percent in the world to an all-time low in the 1970s and neoliberalism's simultaneous take-off around roughly the same period.

Dubbed as a hegemonic ideology by various authors, some of whom I have mentioned above, neo-Marxists do not stand alone in categorizing neoliberalism as 'a big Leviathan' as it is once coined by Collier (2012). Kingfisher and Maskovsky (2008, p. 116) reformulate the general tendency for critical studies of neoliberalism when they state that *"at the level of ideology, neoliberalism has sought to transform the constitution of persons and the relationships among individuals, the market and the state"* and underscore the expansive character of the notion. Even though not every other current of thought and every author writing on neoliberalism are not as straightforward and confident about the hegemonic aspect of neoliberalism, the notable representatives of other prominent schools in social sciences such as institutionalism (Campbell and Pedersen, 2018; Dowd and Dobbin, 2001),

regulationist school and state theory (Jessop, 1993, 2002, 2010) agree on the point that neoliberalism is a political and economic project, dictated to the society in a hierarchical top-down order and whose overarching principles remain the same over the globe.

This holistic approach towards neoliberalism can be and has been criticized by various authors from many aspects. Besides its benefits in terms of constituting a clearly defined theory of neoliberalism in line with a political-economic framework and emphasizing the class-based dynamics of neoliberal transformation of roughly last 40 years, it also accommodates major flaws that need to be addressed both in terms of the concept's clarity and its operational capacity for the rest of this study which adopts a different perspective towards neoliberalism than this totalistic approximation.

Labeled as a *"thwarted totalization"* by Kingfisher and Maskovsky (2008, p.118), even though neoliberalism has totalizing desires, these are never entirely fulfilled (Kingfisher and Maskovsky, 2008). This totalizing projection of the term "neoliberalism" as a top-down project result in an illusion where neoliberalism is perceived to be "omnipotent" and "omnipresent" in the sense that it has been structured as a universal phenomenon serving as the root cause of a staggeringly wide variety of social, political and, economic changes (Clarke, 2008). As is aptly highlighted by Peck, *"even where neoliberalism is demonstrably hegemonic, it is never the entire story, never the only causal presence; it never acts alone"* (Peck, 2013, p.19).

However, hegemonic accounts of neoliberalism often overlook this irreducible character of the term in favor of a totalizing approximation. Thus, what we are left with: nothing but a distorted version of the reality we are bound to, and a uniform, top-down, self-imposing, globally prevailing image of neoliberalism as an ideology starts to emerge as a result. Furthermore, the path-dependent character of neoliberal projects on various levels such as national, regional, local context have been left out of assessment, and the legacies of inherited institutional frameworks, policy regimes, regulatory practices, and political struggles have been shut out of the equation (Brenner and Theodore, 2002). Though the critical literature on neoliberalism provides

enough proof for delving into the specific characteristics of varied manifestations of neoliberalism; it is of crucial importance to highlight that, even where neoliberalism yields similar consequences in terms of its implications, a different form of policies it generates, and so on, the motivations and the path to this convergence may differ quite substantially in a different local context (Fourcade-Gourinchas and Babb, 2002). Hence, looking at local manifestations of neoliberalism and marking deviations and diversions from the *"utopian idealism of free-market narratives"* (Peck et al., 2018, p.3) envisioned by hegemonic accounts of neoliberalism is of vital importance to take a step forward in transcending that uniform, unilinear, ever-present and omnipotent conception of neoliberalism and discovering discrepancies of lived experiences of neoliberalism from that abstraction.

On the other hand, bringing variegated versions of neoliberalism on various levels to the fore and focusing on its local manifestations is only one step towards ascertaining the fragmented, porous structure of neoliberalism acting upon our daily existence. A myriad of accounts privileging that side of the story still hold a structural view of neoliberalism and look for unifying patterns in these scattered local manifestations that they have as bits and pieces of a master narrative of neoliberalism. Doing that, they mostly tend to ignore basic questions such as how neoliberalism shapes up to affect the everyday lives of every individual and got affected in turn, in what different ways it relates to those individuals who are parts of the social tissue and how it circulates in the society and how it is (re)produced as one of the dominant discourses of our time (Larner, 2003; Hilgers, 2011; Springer, 2012). Larner claims that *"because neoliberalism is most often understood as either a unified set of policies or a political ideology, there was virtually a complete silence on the techniques of neoliberalism, the mundane practices through which neoliberal spaces, states, and subjects are being constituted in particular forms"* (Larner, 2003, p. 511).

As a researcher, I do not intend to retain that silence as my thesis digs directly into the subjective terrain of primary healthcare professionals that are significantly affected and quite radically transformed with a forcefully imposed health care reform labeled as "neoliberal" by many critical voices (see Coşar et al., 2009; Yörük, 2012; Başkavak et al. 2013; Yılmaz, 2017; Ağartan, 2015; Çakıroğlu et al., 2016; Ağartan et

al. 2019). However, doing that requires a balanced effort to keep track of both subjective positions of primary healthcare workers and the neoliberal policy framework as one of the primary loci of the subjectivities of those individuals. These two principal methodological concerns also inform the theoretical ground of this study and make it compulsory to mention how neoliberalism is tackled by "actually existing neoliberalism" and "governmentality" studies as they constitute the major theoretical fulcrums to frame neoliberalism for this account.

1.4. Actually Existing Neoliberalism(s)

Jamie Peck et al. (2018) explains the necessity for generating a term such as actually existing neoliberalism in the introductory remark to their article titled with the same name as the concept in the following quote:

> *"The notion of actually existing neoliberalism would hardly be necessary were it not for the marked but also constitutive discrepancies between the utopian idealism of free-market narratives and the checkered, uneven, and variegated realities of those governing schemes and restructuring programs variously enacted in the name of competition, choice, freedom, and efficiency"* (Peck et al., 2018, p.3).

As this citation indicates, the genesis of the term "actually existing neoliberalism" is deeply rooted in the works of critical human and economic geographers who insistently underscored the polymorphous structure of neoliberalism that is far from a hierarchical hegemonic ideology. When considered from that point of view, the first premise of that line of thought was to challenge the geographical coordinates of the hegemonic discourse of neoliberalism whose unmitigated epicenter was both sides of the North Atlantic and specifically the US and the UK. It began first as an intellectual movement and was soon to be developed into an alternative to the Welfarism as the post-WWII status-quo of Keynesian economics started to shatter beginning from the 1970s, and it quickly became hegemonic under the political

leadership of Margaret Thatcher and Ronald Reagan in the UK and the US respectively.

The precursors of the term "actually existing neoliberalism" do not deny the North Atlantic origins of neoliberalism. On the contrary, they recognize the region's s primacy in spearheading neoliberalism both as an intellectual movement and a specific set of policies (Brenner and Theodore, 2002; Tickell and Peck, 2003; Peck, 2010). However, what they particularly object to is the hierarchical dominance of North Atlantic neoliberalism over the other parts of the world and the convergence of neoliberal policies and programs all over the world into one single neoliberal agenda dictated by this so-called center. As it is emphasized by many within that stream of thought (Peck and Tickell, 2007; Leitner et al., 2007), neoliberalism *"is, above all, a constructed order, emerging in variegated ways in different places, in response to local challenges as well as nonlocal influences, rather than diffusing worldwide in stable form from a single birthplace"* (Leitner et al., 2007, p. 314). This opposition on the point of privileging one geographical locus over others is highlighted in an even more striking manner by Clarke when he states, *"Neoliberalism does not, and cannot, exist in pure form, but only manifests itself in hybrid formations. Even the Bush and Blair projects, located as they are within the neoliberal 'heart-land,' are appropriately characterized as hybrids, and as such, they are no 'less hybrid' than the neoliberalizing regimes of Chile or Mexico"* (Clarke, 2008, p.140).

As mentioned above, the keyword that also stresses the processual character of neoliberalism is "neoliberalizing". It is a derivative of the term "neoliberalization" coined by this current of thought, and that underscores the processual nature of neoliberalism where no readily-present, end state to adopt and pursue is available. *"There is no one set of 'neoliberal states' and another set of 'non-neoliberal states; neither is their straightforward transitions from one to other, but a range of nationally and locally specific and qualitatively differentiated forms of neoliberalization,"* writes Tickell and Peck (2007, p.165) in a quote that underlines the evolving character of neoliberalism. This special emphasis on the "neoliberalization" instead of end-state neoliberalism putting the hierarchical view of hegemonic neoliberalism emanating

from a center aside and enable local accounts of neoliberalism to come forward and to be treated as equals with each other on a horizontal plane.

Another concept that needs further clarification about the processual character of actually existing neoliberalism(s) along with the introduction of the term "neoliberalization" as a process is the "variegated neoliberalization." Variegation here refers mainly to the path-dependent character of neoliberalization (Peck et al., 2018). When Peck underlines that *"neoliberalism must inescapably and in every situation, be located amongst its others"* (Peck, 2013, p.19), he actually makes a point in highlighting the preceding status quo prior to neoliberalism in each account and reminds us once again that neoliberalism, like any other dominant ideology, never operates in a vacuum. Thus, neoliberalization is defined as a process not only in its dynamism and its proneness to malleability in different situations but also *"that unfolds and becomes embedded in previously existing institutional orders which, in turn, respond and react through diverse neoliberal formations"* (Knio, 2019, p.2). This particular highlight on path-dependency that is the consequence of the uneasy cohabitation of previous institutional frameworks with a neoliberal program and policies allows us to assess neoliberalism in its various instantiations through different moments in time and different spaces, furthering our capacity to nuance this process that we call neoliberalization and opening up new channels to make sound comparisons between various experiences of neoliberalism in different local contexts.

All these efforts to overcome the limitations of hegemonic accounts of neoliberalism and the issues that are emphasized by actually existing neoliberalism also shed light on this study in more than one way. As a local account of neoliberalism, that deals with the subjective effects of neoliberalization in the primary health care provision in Turkey; actually existing neoliberalism literature provides this study a richness in grasping the extent of neoliberal healthcare reform in the country and meditating on its ramifications and converging and diverging moments with the hegemonic view of neoliberalism. This variant of neoliberalism also enables us to mark the cornerstones of Turkey's neoliberalization process roughly for the last forty

years and make sense of the context where the neoliberal reforms took place and the evolutionary stages of the neoliberalization of health care.

Notwithstanding that the benefits of employing actually existing neoliberalism seem rather evident in any study tackling neoliberalism, it should be noted that the approach also has an inherent weakness that needs to be addressed both as a general notice and a limitation for this study. In my opinion, this weakness is best captured by Wendy Larner in a critical account of other classificatory efforts of neoliberalism, including actually existing neoliberalism. Larner reminds us of the sheer neglect of the various *"techniques of neoliberalism, the mundane practices through which neoliberal spaces, states, and subjects are being constituted in particular forms"* (Larner, 2003, p. 511). Even though some of the critical accounts on neoliberalism mentioned the subjective effects of neoliberalism, they have often been framed in terms of an omnipotent state power who was able to force individuals to act in a certain way, and any forms of the agency have been deprived of those individuals in these accounts of neoliberalism (Larner, 2003). The author's criticism is at its fiercest when she highlights that *"such analyses of neoliberalism may explain the creation of particular subject positions, but not that of acting subjects"* (Larner, 2003, p.511).

Her insistence on subjectivity formation and different techniques of neoliberal subjectification has been significantly absent in other accounts of neoliberalism. This emphasis on the comprehension and revealing of subjective positions affected by neoliberalism is embedded within her academic affiliation with governmentality literature that flourished around French thinker Michel Foucault's influential writings. This post-structuralist take on neoliberalism also constitutes the theoretical backbone of this study that puts in its center subjective experiences of primary healthcare workers in İstanbul and tracing their everyday lives at work. Henceforth, this study will concentrate on the central tenets of governmentality theory and highlight what makes it distinctive regarding others in terms of coming to terms with neoliberal subjectification where they have failed so far.

1.5. Neoliberalism and Governmentality

When neoliberalism is defined as a type of "governmentality" in the Foucauldian line of thought, and when this is adopted as the main theoretical axis of a study as this one aims to do, it is inevitable to seek a clear and concise definition for the term. Since neoliberalism is defined as *"an art of government"* (Foucault et al., 2008) at the very beginning of Foucault's influential 1978 College de France lectures on neoliberalism, one of the better ways of doing it lies in searching for what the term "government," as the etymological root of the concept, entails in Foucauldian terminology beyond its conventional implications.

Famously formulated as *"conduct of conduct"* by the French thinker himself (Foucault et al., 2008), the concept of government extends over the straightforward uses of the term that roughly equates it with "the state" in most accounts. Benefiting from the linguistic possibilities of the word "conduct," Foucault thinks of the government, not as a unidirectional activity where power is exerted from one source in a top-down dynamic within the boundaries of a hierarchical political system (Dean, 2010). On the contrary, the crucial part of his definition of government points to *"the government of the self"* in the sense that it also involves an ethical significance the word conduct is conceived as in the case of the reflexive verb *"to self-conduct"* (Dean, 2010, p.17).

From this point on, the concept of "government" transforms into a decentralized concept in which no center for power is yet to be identified, where the power is conceived as a scattered mechanism springing from various sources. In this formulation of "conduct of conduct," government, then, appears to emerge as:

> *"(...) any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seek to shape conduct by working through the desires, aspirations, interests, and beliefs of various actors, for definite but shifting*

ends and with a diverse set of relatively unpredictable consequences, effects and outcomes" (Dean, 2010, p.18).

Dean's definition of the Foucauldian concept of government also serves as an entry point to the broader category of *"governmentality."* Even though various names are claiming that the term governmentality is the outcome of a wordplay combining the words *"government"* and *"mentality"* (Miller and Rose, 1990; Rose and Miller, 1992), Sennelart (2007, p. 399-400) clearly underlines that the term governmentality has the same relation to *"governmental"* such as *"spatiality"* does to *"spatial"* and so on. From that point of view, it will not be wrong to argue that this linguistic framing of the term leads us to a place where governmentality is expressed as an inquiry on the "how" of governing instead of searching for a normative basis for the source and diverse manifestations of power.

Before moving on to the gist of neoliberal governmentality that lies at the core of this study, it would be of use to underscore that governmentality is a term that serves a double function for Foucault himself and other Foucauldian studies as well. On the one hand, it refers to a specific moment in time in Foucault's genealogy of power that points to the historical transformation of the way(s) that power is conceived and exerted have been shifted. However, governmentality also refers to discovering and understanding a wide variety of government techniques within a particular spatial framework that one could call *"government at a distance"* (Rose, 1999, p.49). In this study, the genealogical approach to governmentality would be left out. The latter one is adopted as the main focus of the study does not lie in a historically-oriented inquiry but in discovering daily tasks, actions, and behaviors of a particular occupational group whose subjectivities have been touched and directly targeted on occasions by a neoliberal shift in political, social and economic levels.

This neoliberal shift whose diverse manifestations on multiple fields such as healthcare, education, statistical studies, risk assessment, monitoring and securitization, computing, criminology, addictive behavior, psychiatric processes, etc. (see Garland, 1997; McGregor, 2001; Elden, 2007; O'Malley, 2008; Binkley, 2009;

LeBesco, 2011; Gowan et al., 2012,) have been thoroughly catalogued and elaborated by governmentality studies provide us enough information to talk about a distinctive form of "neoliberal governmentality." Even though many features of this novel form of governmentality can be stressed out in detail, here, I will limit the discussion to two main traits of neoliberal governmentality that would also lead up to a better understanding of neoliberal subjectification that is the primary concern for this research.

Neoliberal governmentality is a concept that first appeared in Foucault's influential College de France lectures in 1978, and it quickly became a useful alternative for those who were seeking out an explanation beyond the political, economic point of view of structuralist accounts of neoliberalism (Leitner et al., 2007) who were always stressing out the agency of the state and other political actors in the deployment of neoliberal principles and policies. Foucault's take on neoliberalism's major novelty is its reimagining of the market as *"the inner regulator of the state rather than the state as the external regulator of the market"* (Lemke, 2001 paraphrased in Leitner et al., 2007, p.3). This feature constitutes the significant difference of neoliberal governmentality approach compared with other critical accounts of neoliberalism. This is one of the most distinctive aspects of neoliberalism as a form of governmentality compared to classical liberalism (Leitner et al. 2007).

Another co-constitutive and complementary trait of neoliberal governmentality is what Rose (1999) calls *"government at a distance."* That does not specifically mean to be a retreat of the state from the space that it previously occupied, but a novel spatial reconfiguration where the state remodeled in the form of a market recognizes a certain degree of freedom for its respective constituents (Rose, 1999). Doing that, Foucauldian approach to neoliberalism as a form of governmentality suppose that *"the state, rather than being something 'out there' acting upon society and individuals, is mutually constituted in and through an assortment of social relations and materialized through innumerable socio-spatial practices in innumerable spaces"* (Larner, 2000; Crampton, 2012; Kingfisher, 2013; paraphrased in Ward and England, 2016, p.57).

The immediate consequence of this constant emphasis on the processual character of the state that is continuously being reconfigured around a market-centric mentality back and forth is the opening-up of new opportunities for more contingent accounts of neoliberalism that does not treat the state as a monobloc powerholder and yet bringing various instantiations of different moments of neoliberalism to the forefront. Another crucial strength of studies of neoliberal governmentality is its focus on neoliberal subjectivity that it was possible to identify in the absence of a privileged agency to any overarching body of authority, including the state; and the claim of governmentality studies emphasizing the rearrangement of the whole of social existence, including individuals, in an image reflecting market principles (Brown, 2015; Nadesan, 2010). Even though studies of neoliberal subjectivity formation constitute a relatively new locus of attention in general Foucauldian theory of neoliberal governmentality, it quickly became one of the most exciting theoretical lenses to discover further effects of neoliberalism in daily human existence, and it unavoidably needs to be addressed here more in detail as this study is first and foremost an effort to tackle with the effects of neoliberalism on the subjective level.

1.6. The Neoliberal Subject

The theory of neoliberal governmentality developed by Foucauldian scholarship initiated many novelties in framing and interpreting neoliberalism as a real-world phenomenon that had been discussed, supported, sometimes embraced, objected to, and sometimes plainly rejected by various other accounts. However, possibly none of those novelties were lauded and praised as much as its emphasis on the effect of neoliberalism on the level of subjectivity formation. As Dean (2010) points fittingly, both the supporters (Dardot and Laval, 2014) and the dissidents (Lazzarato, 2011; Mirowski, 2013) of Foucauldian framing of neoliberalism agree with regard to the significance of the process of neoliberal subjectification and its centrality for highlighting what is "neo" about neoliberalism.

Nonetheless, one should also remark that despite its centrality over the Foucauldian formulation of neoliberalism and its universal appraisal, the process of

neoliberal subjectification has not been theorized and elaborated by Foucault himself beyond his insightful discussion regarding the differences and similarities between the restructuring of German and American economies following the Second World War and on *"The Birth of Biopolitics"* (Foucault, 2008). In this regard, it is of particular interest to mention his analysis of homo oeconomicus concerning the *"human capital"* theory spearheaded by Gary Becker (2009) and how the term has come to be evolved and redefined with respect to its genesis in the writings of the precursors of classical liberalism such as Adam Smith.

For Foucault, the meaning and implications of the term *"homo oeconomicus"* have been radically altered and reformulated by human capital theory in a way reflecting the particularity of American neoliberalism. As he underscores rather elegantly, human capital theory supposes that all elements of human existence that both determine and constitute the character and behaviors of an individual, including even the innate qualities of human life, including the genetic make-up of a person, can be seen as features to be developed and enhanced (Foucault, 2008).

Although random criteria do not define this new emphasis on enhancing one's human capital, it is defined as a function of its possible economic gains that contribute to material well-being and individual status. Foucault's interpretation of human capital theory builds up to a conclusion where *"'all these aspects of human life can enter into economic analysis 'as behavior in terms of individual enterprise, of enterprise of oneself with investments and incomes'" (*Foucault et al., 2008, p. 230; quoted in Dean, 2014, p.31)—on the other hand, treating the subject as homo oeconomicus does not necessarily mean that the totality of subject becomes defined by its congruity with economic criteria. On the contrary, referring to the human capital theory, Foucault suggests that defining subjects as homo oeconomicus means that *"economic behavior is the grid of intelligibility that one will adopt on the behavior of the new individual (...) power gets a hold of him to the extent, that he is homo oeconomicus"* (Foucault et al., 2008, p.252). He grounds his argument while discussing American neoliberalism's specificity that uses the market rule as a founding ethos for human

subjectivity and seeks *"a principle of the decipherment of social relationships and individual behavior"* (Foucault et al., 2008, p.243) in parallel with this founding ethos.

However, neoliberal subjectification is but one part of neoliberalism's general conversation, as elaborated by Foucault. It was one of the areas left to be developed by other authors who followed in his footsteps. Between then and now, a considerable literature on neoliberal subjectification, constituting one of the major sub-fields of neoliberal governmentality studies, has sprung (for some notable work see Bondi, 2005; Dilts, 2010; Layton, 2010; Binkley, 2011; Gill and Scharff, 2013; Ball, 2016; Scharff, 2016; Dean, 2017) which is hard to tackle here in its entirety, owing both to lack of space and the orientation of the study whose main objective is not to proceed a theoretical discussion on different accounts regarding neoliberal subjectification but to use the perspective as a general framework for the fieldwork that constitutes the core of the thesis. In this regard, I will employ the framework proposed by Pierre Dardot and Christian Laval (2014) as the central theoretical axis on my inquiry of the neoliberal subjectification of primary health care workers in Turkey as it constitutes one of the most clearly organized and concise accounts of subjective effects of neoliberalization from a Foucauldian perspective in a way that also reflects and encapsulates the essential arguments raised by former inquiries on neoliberal subjectification preceding it.

Dardot and Laval (2014) detail and nuance what they call *"neo-subject"* of neoliberalism in many ways that will be elaborated and contextualized in the upcoming chapters in the context of the neoliberal subjectification primary healthcare workers in Istanbul. However, here I content to give a general outline of their understanding of the neoliberal subject to pursue a more concise plan and not overwhelm the reader before jumping on the fieldwork findings' presentation.

As they contend in the light of the Foucauldian literature, upon that the study in hand is rested, the most fundamental aspect of the neoliberal subject is her becoming a personal enterprise that interprets her existence in line with economic thinking and whose primary intent is to maximize her material well-being (Dardot and Laval, 2014).

This entrepreneurial self-government of the subject, claims Dardot and Laval, is obviously more than the so-called enterprise culture discourse that has become increasingly popular lately. This becoming towards an enterprising-self is poised to cover the working-self and the totality of one's existing diverging from her/his family life, personal relations, leisure time, etc. (Dardot and Laval, 2014,). In that respect, it is a totalistic project, and *"all its activities must be compared with a form of production, an investment, and a cost calculation"* (Dardot and Laval, 2013, p. 263).

This enterprising-self, characterizing the neoliberal subject, is defined by some notable qualities that should be underlined here. First of all, this subject is an autonomous and active person who is willing to do what it requires to optimize her/his life chances and is ever-present to adapt to ever-changing and flexible conditions of her/his environment. Defined by a pro-active attitude towards the uncertainty surrounding her/him, this autonomous and active subject is framed within a discourse of competitiveness that becomes the measure for all of her/his actions and driving impulse in the way of becoming a subject that cannot afford to lose (Dardot and Laval, 2014). She cannot afford to fail simply because this subject is *"both the worker who accumulates the capital and the shareholder who enjoys"* (Dardot and Laval, 2014, p. 297) the consequences of his active behavior where all the possible gains and losses are reviewed at the expense of others.

Recalibrating neoliberal subjects around an individualized logic of competition requires activating certain mechanisms that will perpetuate this self-enterprising subject. Dardot and Laval (2014, p.275) aptly describe that competitive subject *"who must maximize his results by exposing himself to risks and taking full responsibility for possible failures."* This quote introduces notions of "risk" and "self-responsibility" as two of the founding features of the neoliberal subject in a way presenting themselves as mechanisms that balance each other out for the appearance of an ideal neoliberal subject. The peculiar point about risk and responsibilization becoming two of the prominent features of this competitive enterprising neoliberal subject lies in the fact that both risk and responsibility are mobilized for the individualization of the neoliberal subject, and "the social" aspect is framed more and more like a residue in a

system where individuals are held responsible for their success and failure both at the same time (Dardot and Laval, 2014).

For Dardot and Laval, this novel subject of neoliberalism whose chief qualities are listed above are not the conclusion of a natural, untouched process that has occurred within a spatiotemporal framework unfolding a chain of events rendering this outcome inevitable. On the contrary, this enterprising-self's appearance is the result of a carefully tailored process, shaped by what one can call "technologies of government" (Rose, 2000) in Foucauldian parlance. These technologies are numerous, and most of the time, a multiplicity of them are at work. However, some of those that are crucial for the composing of the neoliberal subject can be counted as evaluative technologies and quantification mechanisms such as performance criteria, setting targets for the completion of specific tasks, the introduction of grievance mechanisms working in a way aiming both at controlling individuals and allowing them to act in accordance with the basic principles of competition to maximize their material gains (Dardot and Laval, 2014).

These governmental technologies will be elaborated and nuanced further in the upcoming chapters in the context of the everyday narratives and workplace experiences of Turkish primary healthcare workers who have been submitted to similar procedures and have been expected to act by the novelties brought about by those procedures. However, it is crucial here to underline that neoliberal governmental programs are not implemented in a vacuum, and neoliberal policies are almost always accompanied by such mechanisms seeking to carve out a subject who is willing to adapt novel conditions triggered by neoliberalism.

Adopting neoliberal subjectification as the main theoretical framework for this study is beneficial for more than one aspect that I would like to mention here. First of all, even though the studies of neoliberal governmentality became one of the main sub-branches of the studies of neoliberalism in general; they have tended to focus, for most of the time, *"on official discourses, as read through government policy documents"* (Larner, 2000, p.14) instead of directly focusing on specific neoliberal programs

implemented elsewhere in the world. In that respect, it is possible to claim that governmental accounts on neoliberalism enable us to have a profound grasp of the structural and spatial aspects of neoliberal transformation yet at the same time offering very little in terms of *"how subjects and subjectivities are formed"* (Jessop and Sum, 2001, p.97). For Foucauldian literature on neoliberalism, this results in being poorly integrated and interacted with the dominant regulationist literature on neoliberalism, of which the accounts of actually existing neoliberalism occupy a central place (Miller, 2007). Independently speaking from the heated debate on how and to what extent it is possible to reconciliate Foucauldian and structuralist approaches on neoliberalism (for an extensive discussion, see Barnett, 2005; Springer, 2012), reckoning with the neoliberal subjectification may contribute to the studies of neoliberal governmentality in a way shedding more light into the process what Nikolas Rose calls "translation." The process of translation can be formulated as delving into the different courses of action to understand how *"(...) alignments are forged between the objectives of [central] authorities wishing to govern and the personal projects of those [local] organizations, groups, and individuals who are the subjects of government"* (Rose, 1999, p.48).

Another considerable advantage of employing neoliberal subjectification as the main theoretical framework for this study stems from the particular research area in which this study is situated. As qualitative fieldwork on primary health care workers' subjectivities, this account of neoliberalization of healthcare in Turkey is closely related to the literature on the effects of neoliberalism on the welfare state. Studies of neoliberal governmentality in general and studies investigating the neoliberal subjectification process to be more specific open *"useful avenues for the investigation of the restructuring of welfare processes"* (Larner, 2000, p.6). For Larner (2000, p.12), *"these analyses show that new political configurations are more multi-vocal than that we might previously have understood (...) and that close inspection of particular neoliberal political projects is more likely to reveal a complex and hybrid political imaginary, rather than the straightforward implementation of a unified and coherent philosophy."*

This quality of adopting the neoliberal subjectification framework, allowing us to nuance the specific effects of neoliberal programs and implementation of neoliberal policies on the everyday lives of individuals, will hopefully constitute one of the significant contributions of this work to the literature of Turkish neoliberalization that so far came to be treated much more straightforwardly in line with the traditional structuralist readings of neoliberalism. In that respect, I hereafter will formulate the main questions, leading this research and puzzling me from the first day when the seed of curiosity has been planted in my mind concerning neoliberalism and Turkish neoliberalization.

1.7. Research Question and Research Objectives

In preceding sections, I have tried to convey the theoretical framework that has guided me through my research so far. The Foucauldian literature on governmentality and neoliberal subjectivity both enriched and informed my inquiry on primary healthcare workers while trying to build up my arguments up until this point. Most importantly, it dramatically altered the way I interpreted neoliberalism beyond its conventional connotations and enabled me to frame this study properly by asking sound and appropriate questions about a field that has not been hollowed out deep enough by previous studies of social sciences in Turkey so far, except a few significant yet isolated examples.

In this regard, the main question that I will try to answer during my research is how and to what extent the neoliberal subjectification is reflected through the Turkish primary health care workers whose working environment and conditions have been radically transformed around the Family Health Center (FHC) model introduced by the Health Transformation Program (HTP) that has been brought into force in 2003? The question can also be rephrased in the following way: What is, for the primary health care workers in Turkey, the subjective manifestations of neoliberalization of health that the HTP has triggered through the FHC model in a way allowing them to act as neoliberal subjects? While delving into the study, I will try to understand how the neoliberal transformation of the health care system in general and the primary

health care provision, to be more specific, affected the everyday subjectivities of health care workers residing in İstanbul guided by qualitative fieldwork collected from multiple interviews.

However, three main motivations leading to this study in general and the formulation of those research questions needs to be clarified in the first place. It needs to be mentioned that the selection of primary health care workers for this study instead of their colleagues working in secondary and tertiary health care is not in vain. Even though HTC transformed all parts of the Turkish health system considerably in roughly the last twenty years in line with neoliberal principles, primary health care differs in respect to adopting a much more self-entrepreneurial agenda with Family Health Centers replacing Community Health Centers. Another reason for picking primary health care workers as subjects of this study lies in the fact that the most dramatic labor arrangements and alterations regarding the health care providers have been put into effect in this section of the system. Once having the essential personal benefits and protections of civil servant status, primary health care workers have been transformed into contract employees and precarized under this new labor regime. The third and final motivation for those questions is rooted in the sheer lack of qualified and well-grounded studies focusing on the neoliberalization of healthcare in Turkey and its effects on primary healthcare workers beyond some notable exceptions.

Nevertheless, these questions remain too vague and too broad for this study's scope and ambitions, and the implications and purview of the neoliberal subjectification process should be developed and adequately framed. I now envisage investigating three separate but inter-related aspects of primary health care workers' work-based subjectivity to tackle those basic questions more insightfully. First of all, I problematize primary health care workers' subjectivities in conjunction with the spatial transformation that occurred with the FHC model's launch, built around a model seeing these new institutions as small enterprises that need to be managed by general practitioners working there. The second area of problematization regarding how the neoliberal subjectification process affects those workers necessitates looking at their respective relationships with their coworkers in FHCs that are also rooted in

the novel working regime introduced by the HTP. The third and final sphere to be problematized concerning primary healthcare workers' subjectivities requires taking a closer look at how their relationship with their patients has been altered by the new measures introduced by the FHC model to challenge the traditional expert authority of physicians.

These problematized aspects specify and crystallize the basic questions sitting at the center of this study. They have also reflected in the organization and the classification of the following chapters presenting the fieldwork findings. During the next section, I will give a brief outline of the thesis to underscore how I will address those questions more in detail before moving on to the main discussion.

1.8. Research Methodology

This study has been originally planned as a field work that would include face-to-face interviews with the participants in their workplaces. However, the limitations imposed by the current pandemic conditions made in person interviews practically impossible and the emergent product took shape within a forced methodological necessity rooted in employing online reviews as a consequence. The fact that the sample of the study consisted of a group of family physicians whose susceptibility to catch the COVID-19 virus is significantly higher compared to the other sections of the society, and the FHC as a possible location for the interviews where susceptibility to the exposure to the virus is threatening for a researcher aggravated the primacy of an online fieldwork not as an option but an obligation.

Pursuing an online fieldwork has some notable drawbacks imminent to the use of this methodology as pointed by the respective literature. Technical issues such as “dropped calls and pauses, poor audio or video quality, and the inability to read nonverbal cues as a result of inconsistent and delayed connectivity” has been mentioned by various authors (Deakin and Wakefield, 2014; Weller, 2015; paraphrased in Archibald et al. 2019). The other difficulties arising from the use of online methods of interviews referred to the undermining of “traditional

understandings of participation and immersion" (Howlett, 2020) and emphasized the limitations embedded in the "head shot" provided by cameras of the technological devices used during the interviews curbing a proper observation of the body language, gestures and the tone of a participant (Cater, 2011; paraphrased in Janghorban et al., 2014).

However, as an obligatory choice rather than an informed choice, even though employing online interviews presents some obstacle to conduct a fieldwork, it has its own advantages to be emphasized here, as well. First of all, the synchronous nature of video calls could contribute to recreate the intimate nature of on-site interviews (O'Connor and Madge, 2017). The major problematic aspect of conducting online interviews concerning what constitutes the "field" in an online study is answered in a way that highlights the replacement of "co-location" with an online "co-presence" (Beaulieu, 2010; paraphrased in Howlett, 2020) between the researcher and the participants ensuring the creation of a "new digitally and socially meaningful space" (Howlett, 2020). The initially unthought benefits of using online interviews such as a much more relaxed communication between the researcher and the participants, a more personable and intimate exchange, a more symmetrical relationship with the participants as participants exert a greater agency during the exchanges (Howlett, 2020). These advantages have been clearly observable during the interviews conducted within the scope of this study, too and even though an on-site field work is still the preferred choice over an online study, it enabled the creation of a suitable medium for the interviews.

The study consists of 21 online interviews, carried out via Zoom as being the preferred online communication platform. The interviews have been conducted from February through early April. Only one of the interviews has been carried out by using WhatsApp video call and recorded with an external recorder due to the lack of an inconsistent connection via Zoom. All of the interviews have been recorded with the consent of the participants both in Zoom and WhatsApp interviews. The timeframe for the interviews ranged between 45 and 90 minutes, while an average interview lasted approximately 60 minutes.

The participants have been reached via snowball sampling. The entry point to the field was through a contact with a family physician in ISTAHED (Istanbul Family Physicians Association) and the other participants have been contacted when the first participant introduced me to five other family physicians via a jointly-formed WhatsApp group. However, it should be notified that the ratio of family physicians who are organized under ISTAHED consisted a third of the total number of participants to the study when it is over.

Out of 21 participants, 12 of them was male and 9 of them was female family physicians. The ages of participants have been ranged between 34 and 52. One but all of the participants have been actively working as of the study timeframe. 19 of the participants were working in Istanbul while 2 of them was family physicians in the city of Diyarbakır, in the southeast part of the country. Employing online interviews as an obligatory methodological choice was beneficial in that respect to contact family physicians who were working outside Istanbul.

The sample consisted of participants who was working both in well-off neighborhoods such as Kadıköy, Sarıyer and poorer sections of Istanbul such as Esenler, Bağcılar and so on. Even though the sample is not wide enough to claim a general representativeness of the family physician population in general, it is crucial to underscore that it consisted of a balanced group that was relatively easy to detect the differences emanating from the socioeconomical factors such as average income, general level of education concerning the demographic composition of those neighborhoods.

The audiovisual data gathered during the interviews have been transcribed into written format after the completion of the field work. A discursive analysis approach has been employed for processing the data and delving into the diverse ways the subjectivities of the participants have been affected by neoliberal subjectification in line with the Foucauldian thinking (Scharff, 2016). Discourse here refers to the distinctive ways the meaning of being a family physician and the repertoire of action

referring to it is constructed, (re)interpreted, contested and even rejected on some occasions in the statements of the participants of the study. Some reservations concerning employing a discursive approach within the vein of governmentality studies aside (McIlvenny et al., 2016), employing a discursive framework enables us to take a deeper look into how the diverse manifestations of a neoliberal subjectification is reflected on the level of linguistic expression during the interviews where everyday practices defining their profession have been discussed throughout.

1.9. Outline of the Thesis

This study, designed to be a qualitative inquiry on the subjectivities of primary healthcare professionals working and living in Istanbul, is organized under five chapters based on the findings of the research at hand. The second chapter deals specifically with the spatial transformation of primary healthcare under the FHC model and its effects on primary healthcare workers' subjective constitution. It consists of thorough documentation of their narratives on how they keep up with the novel spatial configuration of Family Health Centers that are organized around a model structured under the basic principles of a private enterprise in stark comparison with the preceding model of Community Health Centers mainly based on a population-based public health approach. This chapter aims to give the reader an idea of how primary healthcare professionals adopt this novel role of "manager" beyond their traditional role as public health experts and their compliance and resistance level with their redefined roles.

The third chapter is devoted to discovering the effects of how the new FHC model shifted the professional and human relations between coworkers sharing the same working space through the contractualization of labor. The remodeling of primary healthcare provision under the FHC model and introducing new measures setting up a working regime encouraging both competition and cooperation on subjective and inter-subjective levels mean a radical break from the former employment regime in primary healthcare presupposing more or less equal pay for equal work. The chapter's central premise involves revealing the subjective effects of

these new labor arrangements predicated on neoliberal principles, one of whose main objectives is to engender a more efficient subject. This chapter keeps track of the validity of this fundamental claim in the narratives of participants of the research and exposing further consequences of these current working conditions for them transgressing the foreseeable effects of legal founding regulations.

The fourth chapter focuses specifically on the dynamics between patients and health professionals under the new regime of FHC and the evolution of traditional expert authority of healthcare professionals on their patients. The current FHC model and legal regulations introduced by Health Transformation Program yield more power to patients in various aspects. The chapter, while focusing on the effects of this shifting dynamic on primary healthcare professionals, on the one hand, it also tries to tackle the different ways they relate to these changes and how they orient themselves in this new model that frames their relationships with their patients more in line with the service sector discourse where the patient has been defined more as a customer whose needs and desires are to be fulfilled by healthcare professionals.

The fifth and concluding chapter is both a thorough summary of the points elaborated throughout the thesis and a debate of how the thesis contributes to the literature of neoliberalism and governmentality in general and neoliberalization of health in particular. In this chapter, the converging aspects of the conducted fieldwork with the neoliberal governmentality literature will be addressed, and some particularities of Turkish neoliberalization compared with the general critical literature on neoliberalism would be highlighted.

-2-
NEOLIBERAL SUBJECTIFICATION THROUGH SPATIAL RECONFIGURATION

2.1. Family Health Center as a Spatial Reinvention in Turkish Primary Healthcare

Turkey's primary health care provision structure has been radically changed, starting with introducing the Health Transformation Program in 2003. The old Community Health Center (CHC) model that has been in effect since 1961 has been replaced with the Family Health Center (FHC) model starting from 2005. The new model first has been initiated as a pilot scheme in Düzce province of Turkey and has been put into force countrywide in 2010. This transition marked a mentality shift in providing primary health care services as the new model prioritized a more individual-centered attitude over a public health concern.

The FHC model, above anything else, transformed the notion of the workplace for medical doctors working there. First of all, the general practitioner status of medical doctors working in the primary health care provision has been replaced with the title "family physician" under the new jurisdiction. The former civil servant status of family physicians has been lost. A contracted labor regime has been introduced, where the contracts should be renewed every two years by the respective local administrative authorities.

Those contracts delegated the spatial and administrative responsibilities of an FHC to the family physicians. In contrast, in the old system, CHCs were public properties, and the management and the administration of the place were handled directly by the State within a hierarchized health bureaucracy. In the FHC model, family physicians are held responsible for nearly every aspect that is related to managing their workplace, including finding a suitable workplace, paying their rent, buying the monthly consumable materials, hiring their auxiliary personnel and paying their salaries, keeping the place intact and doing necessary modification concerning infrastructure and the superstructure, paying all kinds of bills and so on.

A radical move that should be mentioned here was the introduction of Virtual FHCs emanating from the fact that the number of public buildings was not sufficient for the novel system to properly function, especially in metropolitan areas such as Istanbul, where the former primary healthcare infrastructure was unable to meet the public demand. Unlike the classical model, the Virtual FHCs can be described as follows: FHCs without any physical place and registered population. The family physicians appointed to the Virtual FHCs should start from scratch with no actual building in their service. The total number of Virtual FHCs is unknown as no official reports are available. Though it is estimated that a third of all the FHCs in Istanbul are virtual, this new model is becoming more and more commonplace in Istanbul and for the rest of the country.

The following chapter is an effort in understanding how this novel spatial governance, summarized in a nutshell above, has affected the subjective conditions of family physicians as the main constituent of the FHC model. The data derived from the interviews conducted during the study will be elaborated to provide a better insight in presenting the everyday manifestations of their conditions as family physicians and how they handle the greater responsibilities that come along with the introduction of the FHC scheme.

2.2. Responsibilization Through Spatial Liabilities and Obligations: *"Everything you see when you visit our place, we did it!"*

When Family Health Centers were introduced to the Turkish health system in 2005, one of the most dramatic shifts in the primary health care provision took place in the field of spatial responsibilities tied to the management of newly-founded FHCs. In this new model, more or less in line with other neoliberal healthcare reforms that have been implemented elsewhere (see McGregor,2001; Foster, 2005; Mooney, 2012). The State has receded gradually from the administration of primary healthcare provision as an active player and delegated most of its liabilities and obligations regarding the management of FHCs to the family physicians who were working there.

This resulted in a radical break with their former status as civil servants and caused them to become co-managers of Family Health Centers. In this new management regime, family physicians are provided with a monthly allowance to take care of managerial tasks, updated each year proportionately to the yearly rate of inflation. I will talk more in detail about how family physicians allocate their budgets and how they organize the economic management of the place. However, I would like to focus first on some of the significant ways that they have been responsibilized through this novel spatial arrangement as dictated by the State authority.

As stated at the beginning of this section, under the new spatial reconfiguration of primary health care provision in Turkey, family physicians have been responsibilized in multiple ways, ascribing them the managerial and administrative liabilities of the Family Health Centers. During my online interviews, I had the chance to ask them about their general feelings and opinion in the face of those responsibilities. An overwhelming majority of the participants in the study expressed an easily recognizable feeling of discomfort and uneasiness towards their current status and highlighted that they do not see those responsibilities as a primary component of their profession and medical upbringing.

They also underlined that the HFC model took all the burden regarding the management of the place from the shoulders of the State and left them with the task of running the FHC in line with the business principles. İlkay, a former family physician who exited the system and left the country to pursue a medical career rooted in the insurmountable difficulties he endured during his time in Turkey, highlighted the heavy burden of running an FHC and put me straight when I mentioned that one of the major novelties brought about the FHC scheme was that family physicians undertook *'many'* spatial responsibilities when he corrected my wording and replaced *'many'* with *'all.'* In his emphasis over the extensive responsibilization of the family physicians, he likened their situation to a grocery owner stating that they have to take care of any minor detail in an FHC.

His words indicate the strength of the spatial responsibilization as a technology of government in the formation of a neoliberal subjectivity on the side of family physicians from at least two different aspects that will be discussed here. First of all, his grocery owner example operates as a clear analogy pointing to the business-like character of running an FHC in the new system and the role of this newly defined managerial status for the family physicians. Another point worth to be mentioned in the context of this analogy stresses how this heavy responsibilization contributes to the development of a calculating self where subjectivities of primary health care professionals have economized along the process. As stated by the participant, family physicians are free to choose for their actions in the FHC in the confines of their fixed allowance determined by the state, which forces them to think further about the consequences of their efforts in the form of a ceaseless calculation.

llkay's expression is a clear sign showing how this specific technology of government contributes to thinking in market-like terms for the execution of their profession. Even though it was also possible to observe a strong contention towards the spatial responsibilization of medical doctors who are part of primary healthcare provision, there are a considerable number of dissident voices agreeing with the current system and the spatial responsibilization that comes along. Those who seemed to embrace this novel spatial reconfiguration had a varying perspective, pointing to the different ways such a process could be internalized and become a part of one's subjectivity, though.

Selim, a mid-aged primary healthcare professional who has worked in different sections of the Turkish health system before switching to his current position as a family physician and a person who holds several certificates regarding health and quality management, also emphasized the business-like nature of this novel spatial governance. Differently than the most of his colleagues, though, he mentioned how he embraced those new added features to the primary health care provision as follows:

> *"I think about this place as if I am running a private doctor's office, which I did before coming here. (...) I think my friends are complaining about all*

this stuff mainly because they come from the old system. We should be trained adequately for those responsibilities before starting our careers as family physicians to address this problem. Thus, I think they would stop complaining about this and start seeing the bright side of our situation. A physician should be a diverse person in all senses of the word and should take care of running a health institution and his relations with the personnel and patients alike."

His explicit support on coming to terms with the novel spatial governance should be analyzed on three different levels. First of all, his words are a clear sign for the affirmation of a new kind of subjectivity targeted by this transformation and embracing what comes with the FHC scheme. Another point that should be mentioned concerning his statement is his insistence on the change in the meaning of being a medical doctor in the contemporary world. Selim's words, while blaming others' reluctance to keep up with the novel spatial governance of FHCs imposing the managerial burden of the place to their shoulders, refuse to define the medical profession strictly as taking care of the patients and cure them but expand it in a way involving the managerial responsibilities and human resource management to the equation, as well.

His words on the urgency of educating family physicians on how to take care of their managerial work alongside their medical responsibilities resonate very well with his character as I underlined in the beginning that he had several certificates about the executive part of the job. It also overlaps with two of the central tenets of contemporary neoliberal governance: *'lifelong learning'* and *'self-improvement.'* His narrative is also crucial in stressing out the main anchor point for resisting this new spatial regime by other family physicians and opposing it in a way that is compatible with the neoliberal logic. During my interviews for those against this new managerial role attributed to family physicians, the primary counter-argument was the lack of proper education for handling these new managerial responsibilities and these not being a part of their definition of being a medical doctor. However, Selim's statements on educating family physicians for the unique requirements of their current positions provide not only his

personal views on the matter but reflects some of the core premises of neoliberal subjectivity.

The final point that I would like to elaborate on regarding his statement is the highlight on the new freedom gained by family physicians; most of whom are not aware of yet. When Selim stressed out the new possibilities arising from their current position he also declared the flourishing of those possibilities to be contingent upon getting rid of the "civil servant mentality" that he observed to be dominant in many of his colleagues and to come to terms with this new active and self-entrepreneurial subjectivity. However, his words were opaque in giving out and seeing more clearly how family physicians frame this newly earned freedom, which can be found in another narrative in a more illustrative way.

Celil, a family physician at the end of his 30's and working in an FHC in a low-income neighborhood in the district of Beyoğlu in Istanbul, has a far more positive approach than most of the other primary health care professionals that have been interviewed when asked about his respective stance on the spatial responsibilities and expressed his feelings in a way underlining what the current status of family physicians entail for them.

> *"I am mostly happy about us being the manager of our workplace. I'd like to call it a sort of autonomous managership, and I love it, I have to tell. When you have to paint your room, for example, it's up to you to decide the color. You can decorate your space as you please, and nobody gets to have a say in this (...) You are your measure in this system, and what would take months in the old system can be solved in days."*

A major point worth to be discussed in light of his statement concerns how these novel arrangements allow family physicians to reflect their personality and individuality to their working space. His example concerning the freedom to choose the color he likes for his room shows a strong desire for a workplace per one's personal

preferences, devoid of the usual uniformity of state buildings that is also in close connection with the bureaucratized aspect of the state.

This particular emphasis on preferring a more personalized workspace reflecting one's tastes seems to be operating as a counter-balancing mechanism for family physicians when they try to cope with the consequences of the further responsibilization that comes with introducing the FHC model. This tendency most clearly manifests itself in the rhetoric underscoring the importance of having one's own room in the new model. However, to better understand this strong attachment to one's personal space, we should first examine how the physical organization of the workplace have significantly changed with the transition from the former CHC model to the current situation.

Before introducing the FHC model as the new standard of primary healthcare provision in Turkey, Community Health Centers were responsible for providing primary healthcare to the patients. The general character of the CHC space was much in line with the bureaucratized operation of the primary healthcare services elaborated on during the previous section. These were primarily uniform buildings with a discernable public aesthetic devoid of any ornaments and were designed for principally functional purposes. The interior spatial organization of the place was in tandem with this practical priority, as well. There was a shared doctors' lounge for physicians waiting for the patients during the day, similar to teachers' lounges in schools. Medical examinations were taking place in polyclinic rooms that physicians commonly share; lacking any personal space for physicians working in the CHCs.

The introduction of the FHC model to the Turkish Healthcare System radically changed the physical organization of the working space. Rebranded as FHC, these buildings now require a separate room for each family physician working there, allowing for creating a more private and personalized space. Even though not a major concern for most participants, this novel spatial reconfiguration has been particularly articulated by some of them as a positive feature of the FHC model. Aynur, a 38-year-

old family physician working in Diyarbakır, was one of the main participants who drew my attention to this physical spatial arrangement when she said:

> *"In the old days, we didn't have our room in the Community Health Center. We had one commonly used doctors' lounge and two polyclinic spaces that have been widely shared. We didn't have any privacy during those days. (...) The new system enabled each of us to get our rooms, which feels more private than before. (...) When I shut my door, I know that this is my personal space where nobody can intrude without my permission, and I like this sense of privacy."*

Her direct comparison with the old spatial organization leading to her visible approval for the current situation that prioritizes privacy over transparency and a bureaucratized and uniformized physical arrangement, has been shared by also other family physicians. However, it should also be noted that having one's room runs the risk of instigating other tendencies such as self-isolation and harming, resulting in teamwork between co-workers sharing the same working space. Nevertheless, in such a system that bears the whole managerial burden of the FHC to the shoulders of family physicians, having a separate room operates as a counter-balancing spatial rearrangement, rendering the working conditions for family physicians more bearable as it provides an augmented sense of privacy.

However, despite the generally positive attitude towards having a separate room, it could be claimed that the dominant type of attachment with the place born out of the further spatial responsibilization of family physicians is a familiar feeling of working in a commercial facility translated into different rhetorical uses in their narratives such as *"grocery shop," "business," "firm," "shop."* The employment of a predominantly business vocabulary in defining their workplace presents clear proof that the FHC model indicates a neoliberal shift in the spatial reorganization of primary health care provision in Turkey. However, this business rhetoric, rather than causing an alienation to one's workplace, creates new discursive fields where a strong sense of self-identification dominates the rhetoric of our participant's narratives.

2.2. Identification with the Work Space: "*For me, this place feels like home*!"

The individualizing effect of having one's room creating personal bonds with one's working space for a family physician working in an FHC is a preliminary but insufficient step while discussing the formation of a neoliberal subjectivity through spatial responsibilization. If one desires to fully comprehend how the new spatial governance introduced by the FHC scheme affects primary healthcare workers personally, one should keep chasing the diverse ways family physicians are further responsibilized concerning the genesis of a more entrepreneurial self through the workplace identification. During the interviews, I had a specific inquiry for the participants, questioning their sense of appropriation with the workplace and its possible connection with the spatial responsibilities. It should be underlined that an overwhelming majority of the participants claim that further responsibilization is directly linked to their self-identification with their workplace in one way or another. Having one's room was among the significant motives, as stated by the participants, providing a "homey" environment and creating a safe space to escape from the everyday chaos of the FHC they shut their doors.

However, it should also be noted that a small portion of the participants claimed that the responsibilization process has little or no effect on their appropriation of the place. Therefore, before digging deeper into several different ways the spatial responsibilities affect the sense of self-identification with the location manifesting itself commonly as a sense of ownership, I would like to analyze how family physicians on the disagreeing camp frame this counter-point. Veli, a family physician in his mid-thirties working in Sarıyer district in Istanbul, emphasized the significance of one's innate character regarding embracing his spatial responsibilities in conjunction with his work ethics as follows:

> "*For me, these responsibilities changed nothing in particular with my work ethics. I embraced these responsibilities not out of some external constraint by the State or financial thinking but because of who I am as a person. (...) I*

always saw myself as a kind of mediator between the state and the patients. If I can do my job correctly and fulfill my responsibilities both towards the State and my patients, this is a win-win situation for every party involved in it. (…) I, too, may gain from it as a side effect of this ethical stance if I spend this money wisely."

His statement is significant for this study about his insistence on the appearance of '*human nature'* as the major reference point for his embracement of spatial responsibilities. Veli formulated his position towards self-identification with his workplace framed within a discourse validating the market-prone human nature embedded in himself. Accordingly to his thinking, the double-edged responsibilization towards the State and the patients are treated as a transaction containing the possibility to turn into a monetary gain if executed properly, and rearticulating this compliance with the further responsibilization of the subject as an innate quality is mostly in tandem with the individualizing tendency of neoliberal subjectification process.

Tuğçe, another interviewee in his mid-30s working in an FHC in Maltepe district of Istanbul, also shared similar views concerning the effects of responsibilization towards building a sense of self-belonging to the workplace when she particularly emphasized the significance the role played by one's character in identifying oneself with the workplace. However, her words differed in one significant aspect as she built her argument in a comparative logic with other family physicians when she said:

"*I always cared for where I worked as this is a part of my nature. However, it can be easily said that it changed with introducing these responsibilities for some of the other family physicians. (…) You know, it's all about character, I think! If you are an irresponsible person, you need that kind of constraint forcing you to take care of where you work, but if you are born with a caring attitude and love your job as I do, you don't need someone to come and say 'Do this! Do that! And so on…'"*

An obvious implication that is alluded to in her statement is how she positioned her stance with the attitude of other family physicians. Ringrose and Walkerdine (2008) highlight that the exclusionary dynamics play a crucial part in the constitution of neoliberal subjectivity, and "the other" becomes an essential marking point to set the boundaries of one's personhood. Scharff reformulates that when she claims "the entrepreneurial subject constitutes itself through the rejection of that which it is not" (Scharff, 2015, p.13). In the point made above, it can be seen that how Tuğçe situates herself in opposition with the irresponsible attitude of her colleagues and the negation of others' behavior becomes a constitutive boundary creation for expressing her professional self at work.

These two examples prove that even when the responsibilization is said to be not playing any major role for family physicians to comply with the current spatial regime and the creation of a self-identifying subject with the workplace, or to reject those responsibilities than one's innate character, the ways the discursive formulation and articulation of this *'innate character'* is deeply rooted in function to the redefined spatial responsibilities with the introduction of HFC model and points to the formation of a self-internalizing mechanism rather than a rejection of the role of spatial responsibilization in attaching their selves with their workplace.

However, as is underlined at the beginning of this section, an overwhelming majority already acknowledged the positive correlation between responsibilization and appropriation in the workplace. The first aspect of the self-identification rhetoric is tied to how these spatial arrangements are constituted through the monthly allowance granted to the family physicians for the co-management of an FHC and how the economization of those responsibilities forge new behavioral patterns for family physicians conducting them to care further for their workspace. This tendency was observable in an example narrated by Melda, an experienced family physician in her forties working in the Sarıyer district of Istanbul.

She shared her experience concerning how they had to deal with a severe water leakage issue resulting in an overpriced water bill. They had to take this issue very

seriously as it not only caused a higher bill but also posed a severe threat damaging the building. She underscored that taking direct responsibility for the problem to be solved instead of waiting for the State to intervene provided a faster resolution and caused a great relief for everyone working there. However, an easily discernable sense of relief was not the only observable feeling in her narrative. "*When you solve such a big problem and save your building, one cannot help but start to feel a deeper sense of belonging with it*," she said with a visible joy in her demeanor.

Her example shows clearly that delegation of spatial responsibilities to the family physicians helps to create a kind of subjectivity that identifies with the place and become here the necessary ground for the formation of a self-entrepreneurial subjectivity. However, delving into how this feeling of self-belonging has been developed, emphasizing a significant sub-categorization under the general concept of FHC comes to the forefront where working as a family physician has been interpreted as an 'investment.' This tendency is at its most visible and striking form in the narratives of those who are currently managing or once have managed what is framed as "virtual FHC" and briefly discussed in the introduction.

When the HTP project got underway in 2003, and the first Family Health Centers started to open in 2005, the primary method employed by the state was the transformation of state-owned former Community Health Centers to Family Health Centers. This transformation was partly successful in the cities where the current number of CHCs has been sufficient for accommodating the necessary amount of family physicians to attain the targeted ratio of a maximum of 4000 patients per medical doctor. However, the number of state-owned CHCs was extremely insufficient in some parts of the country, especially in bustling metropoles where the actual number of CHCs were remarkably inadequate in meeting the public demand. For this model to be fully operational, this deficit was a major problem to be addressed by the State authority, and it came up with a solution that laid the foundations of this new model, called a "virtual FHC." According to this new plan, medical doctors have been assigned as family physicians to the vacant positions where no current buildings

that would accommodate the FHC were in place. In this solution, family physicians have been responsibilized for materializing their workplaces starting from the zero.

It should not surprise us that this sense of self-identification with space may be observed more intensely in the narratives of the participants who are/was working in a virtual FHC and experienced the further responsibilization concerning the operationalization of the place starting from zero. To make better sense of their experiences, I chose two examples that will be discussed below. In the first one, Tuğçe narrates how the process of opening a virtual FHC galvanized the feeling of ownership of the place in the following way:

> *"You feel that kind of belonging, if you are the one who built it from scratch. When I was first assigned to one of the virtual FHCs, I had to deal with everything, including finding the place, drawing sketches of the new place compatible with the current spatial regulations, hiring construction forepersons, etc. I worked to complete the place day and night, and the result felt like a second home to me. (...) In the end, it was not a monetary investment for me anymore, and I increasingly became emotionally involved with this place."*

In her late-forties, Nermin, another family physician who operates a virtual FHC at one of the low-income neighborhoods of Şişli district in Istanbul, also emphasized the sense of ownership following similarly working in a virtual FHC. However, her narrative differed from her colleague Tuğçe at one particular point that will be elaborated further on following her statement below:

> *"There is no wonder that you feel like you own the place with your co-workers. Because you pour so much time, energy, and effort into this place, the result reflects your character. One of the side effects of this special bond is that you feel that you cannot leave this place for some other FHC."*

A shared emphasis on both of the narratives concerns the emotional bond created between their workplaces and themselves, transcending the financial commitments consecrated to the opening of the virtual FHCs. This is a crucial point implied in both narratives, belonging to two colleagues who underwent a similar experience in different places in the same city that clearly express the subjective dimensions of neoliberalism transcending its economic implications. Neoliberalism not only operates through the economic realm and *homo-oeconomicus* but also affects and emotions become a part of subjective existence and interconnections and linkages between affects and economic decisions have been forged as it can be observed rather strikingly in those examples, as well.

Another common point to emphasize regarding the sense of ownership following the spatial responsibilization for family physicians working as virtual HFC managers is the elevated sense of commitment to the current workplace. Even though Tuğçe mentioned that she had to switch to another FHC for personal reasons that will not be disclosed here, she underlined how hard it was for her to leave a space where she took care of everything from scratch. This point is more clearly underscored by Nermin, who also expressed how difficult for her to abandon a place where her bonds are structured to prevent her from changing from her current location to another. However, another significant point in her narrative lies in how she frames her belonging to the place and her reluctance to abandon it within the confines of a particular discourse of risk-taking. Her feeling of self-identification with the place is matched with the fear of uncertainty that should be dealt with when one desires to change his/her workplace. In the case of the sample selected for this study, there is a visible tendency to keep the status quo intact for most of the participants interviewed.

One should, nevertheless, be aware that this sense of self-belonging with the workplace does not always produce the desired consequences in terms of medical service quality. I would like to underline here a major potential side-effect of the neoliberal subjectification that may cause harm for the provision of primary healthcare services while enforcing an entrepreneurial subjectivity in a way that incentivizes family physicians to derive further personal benefit under the confines of this novel

model. Asım, a family physician in his forties working in Fatih district in Istanbul, elaborated on the subject quite insightfully when he said:

> *"I think that delegation of these responsibilities to us should not be thought of necessarily as a good thing in itself. When we are the sole measure of our responsibilities, we may choose not to care for the place conveniently because it costs us money. When I see myself as the owner of this place, I can put money over my service quality, because I am free to do as I please. I know many places that work with broken medical devices because it costs a lot of money to replace them with new ones."*

Even though one can see the effects of neoliberal responsibilization here in the form of an emphasis on the emergence of a profit-seeking individual trying to cut back on expenses, the consequences for pushing this profit-seeking tendency is obviously at odds with the initial intentions expressed by the state for the implementation of FHC model targeting a better service quality for the patents and ensuring a more efficient and dynamic spatial governance run by family physicians. Here, it can be observed that this perception of ownership of the place may result in the formation of an approach prioritizing the profit over the quality of medical services provided to the patients.

His emphasis on the necessity of employing auditory processes for preventing the abusive exploitation of their current status is unsurprisingly in tandem with the theory of Foucauldian neoliberal subjectification where individual freedom is framed as freedom of choice and boundary-setting mechanisms such as auditory processes and performance measures serve as the limiting mechanisms defining a possible field of action for an individual. One can immediately see the existence of such a regulatory regime, in the current legislation regulating the operation of FHCs in Turkey, and they will be further developed later on especially concerning the introduction of negative performance measures during the following chapter. However, Asım's contribution to this study proves that direct spatial responsibilization of family physicians may involve

far-reaching consequences not initially predicted by the State as the pioneer of this spatial reform on the primary health care level.

2.3. Blurring of Work Time and Work Space: *"We have WhatsApp to manage our spatial responsibilities."*

One of the major novel aspects to be discussed concerning the outcomes of further spatial responsibilization is the blurring of work time and working space for the family physicians. In the old spatial governance of CHCs, general practitioners working there had pretty much the same status as a typical civil servant in Turkey working in a government office. They had strictly defined medical responsibilities that had to be taken care of, fulfilled, and addressed in a strictly regulated time frame colloquially framed as a 9-to-5 shift.

However, under the spatial governance dictated by the FHC model, the classical spatiotemporal working regime is dramatically disrupted, leading to the development of a much more flexibilized subjectivity regarding time management. Mustafa poignantly describes the functioning of this extended and flexible nature of work in his narrative. He highlights that in this new working regime, working hours are still mostly dedicated to the patients. Though there are many additional spatial responsibilities to undertake that are generally dealt with during extra-working hours. In this new spatial regime, those responsibilities are discussed and implemented during lunch breaks or after completing the working shift during the evenings. However, these are not the only media for family physicians to deal with their extra-medical responsibilities, as stated by Mustafa. *"For minor issues involving the everyday tasks of the FHC, we have WhatsApp to manage our spatial responsibilities. We use it very actively, especially during the nights,"* he says and emphasizes the crucial role played by the instant messaging app.

His discourse on how the classical definition of work has changed for a family physician demonstrates that the distinction between work and non-work has been increasingly blurred for family physicians in the FHC scheme. When the multitude of

spatial responsibilities are added to the substantial number of daily patients, those responsibilities are mostly handled in a timeframe crossing the limits of their official schedule. In this extended working scheme, anytime that falls outside the official working hours increasingly appears as potential working time for family physicians. As underlined in this narrative, the blurring of the worktime also complicates finding an outside to one's work when possibly every moment of the day carries the potential to be invaded by some work-related activity.

Another point to be addressed concerning the blurring of workspace and work time on the side of family physicians involves touching on a particular managerial position within spatial governance of the FHCs. Even though all of the family physicians have been co-responsibilized to some degree, there is obligatorily an executive physician in each of the FHCs to be held accountable by the State for managing administrative and bureaucratic affairs of the place. Those who hold the title of executive physicians have a job description requiring them to be more actively involved in handling all sorts of managerial and administrative responsibilities of the FHC, most of which take place outside the FHC. These individuals, as representatives of their institutions, constitute a formal nexus between the FHC and the outer world. The exclusive responsibilities undertaken by the individuals occupying this particular position are elegantly explained in great detail by Ahmet, an experienced primary healthcare professional, working as an executive physician for more than seven years in his workplace located in Bağcılar district of Istanbul, as follows:

> *"Some days, I have to visit banks, tax office, Social Security Institution, our accountant, all at the same time, and don't even have a chance to visit the FHC. It always feels good to be back at your workplace and consulting your patients because otherwise, you may forget you are a doctor."*

His words are representative of other executive physicians in this study, too. His statement highlights the extra workload specific to this particular position, pointing also to the changing character of what it means to be a medical doctor working in primary healthcare. For those bearing an executive title in their respective workplaces,

both the definition of work and the notion of workplace have considerably extended compared to the old spatial governance of CHCs where a medical doctor was expected to stick to her/his medical duties and not to care about the outside world as the executive duties have been exclusively undertaken by a chief physician appointed by the State.

However, irrespective of their executive positions, their current responsibilization concerning the spatial governance of the FHC and blurring of the concepts such as work time and workspace create a heavy burden for all of the participants manifesting itself in diverse ways. The most common grievance among them focuses on the psychological effects of this burden, dragging some of them to discuss the possibility of early retirement as the only option to cope with the damaging consequences of being a family physician in the current situation. Aynur, a family physician in her mid-forties and working in Ataşehir district in Istanbul, expressed her deeply felt disengagement with the medical profession after switching to family physician status the following way.

> *"Being a medical doctor was not a choice for me. If I had forty lives to live, I would be a medical doctor in all of them. I always thought that I would probably die with my doctor's coat on. However, after all those years in this system, all I can dream about is a peaceful retirement. In the beginning, I tried to resist as an individual, but now I feel that stepping down is the only option to heal my wounds."*

Even though her extreme struggle presents an exception, a similar discontent is observable in almost all of the participants. The age can be thought as a deciding factor here as most of the study's younger participants stated that they try to keep up with the current level of responsibility they have to undertake as family physicians in some way or the other. However, a significant portion of them highlighted the significance of getting some sort of mental support either in the form of psychological assistance or the emotional support from their loved ones to cope with the psychological burden of the work that dominates their whole existence both in and out of work.

As a final remark to that section and a bridge to the next one, I would like to discuss how the blurring of worktime operates on the economization of the subjectivities of the participants, visible in most of their narratives as the extension of work beyond their official working hours makes them question their current payment regime. Ahmet, when he complained about how the extra responsibilities coming with the title of executive physician distract him from his medical duties and his workplace as he has many other responsibilities that had to be taken care of outside the FHC, he also mentioned that *"not getting paid a penny more"* for handling them is another primary source of frustration for him.

The traces of this common grievance can be found in many other participants,. A fitting example by Yusuf on that account, another executive physician in his late-thirties and working in Sarıyer district of Istanbul, exhibits how the expansion of worktime for a family physician can be a potential source of agitation, especially when there is no monetary incentive included for handling those responsibilities that lay outside the official working hours.

> "*This weekend I should be here in my workplace because there is a technical issue concerning the electricity and I have to spend my Saturday here instead of with my wife and children. In western countries, you can't bring a doctor to his workplace unless you pay for it, but we are expected to do it for free on top of everything else. Once you sign your contract, you are expected to be in charge of everything 7/24 if necessary, and your medical duties become a detail besides your other responsibilities concerning the place.*"

His statement perfectly reflects this commonly-shared disturbance on the side of family physicians. However, two further inferences are made based on his narrative on not getting paid more for their efforts outside the boundaries of their officially designated working hours. First of all, the emphasis on not getting paid indicates the propensity for being monetarily compensated for their extra-medical efforts. Even though it manifests itself as a resistance to the current spatial governance of the FHCs,

these narratives also point to a further neoliberalization of their subjectivity in the form of an implied search for a monetary equivalent for handling these extra-medical activities. As a far-fetched inference out of the participants' narratives, it can be claimed that their readiness to adopt this extended definition of a family physician is partly conditioned to be financially rewarded by the State for their extra-medical efforts stretching the boundaries of both worktime and workspace. His narrative leads us, here, to face a novel aspect of this spatial regime, as investigating the different ways concerning how the subjective existence of the participants of the study has economized through this extensive responsibilization appears as an equally important point as the responsibilization itself.

2.4. Economization of the Self Through Spatial Responsibilization and the Myth of Toilet Paper

One of the most striking aspects of this novel subjectivity is how the spatial responsibilization of family physicians affects further economization of their choices and actions when handling the daily tasks they need to care for in keeping the FHC running smoothly. These responsibilities can be summarized under four broad categories: paying the rent, paying the bills, providing daily consumable materials for the FHC, and the employment of extra personnel when needed. The last one will be elaborated further on in the next chapter concerning the transformation of work relations between co-workers in the FHC. However, the first three categories will be addressed in great detail during this section.

How family physicians deal with their rent in the current system as it constitutes the most substantial monthly cost for many primary healthcare professionals is the primary category to be tackled here. In the current system, rent paid by family physicians is the primary cause of a deeply rooted inequality reflected in family physicians' choices regarding their workplaces. To give a better picture of how this inequality is perpetuated, one should look closely at the general dynamics of the FHC portfolio operating under the primary healthcare system in Turkey.

An FHC building can be either publicly owned by the State or the municipalities, or a privately-owned property where family physicians pay the rent, following the price dynamics determined by the property market. It should not be concluded, in that respect, that family physicians working in a public building are exempt from rent; as they should also pay a certain amount monthly, determined by the State or the municipality. However, the amounts paid for the publicly-owned buildings pales in comparison to the amount paid for private properties. In some of the smaller towns in Anatolia, the family physicians construct their own buildings; making them the landlords of their own FHC in a strikingly entrepreneurial fashion. However, study's participants state that it is a marginal phenomenon that should not be overstated in its importance, and there is no such example in the sample of this study as having a piece of land in Istanbul, where the property market is highly inflated as opposed to the rest of the country, is nearly impossible for any family physician practically.

This spatial inequality triggered by a heterogeneous portfolio of FHCs creates a situation where the choice of the workplace for family physicians reflects the fundamental market principles. Under this spatial governance, publicly-owned properties become the obvious pick for any primary health care professional who desires to allocate a less significant portion of her/his monthly allowance for paying the rent. Nonetheless, the amount of publicly-owned FHCs are highly scarce as an ever-growing percentage of FHCs are privately owned. In these circumstances, to be employed in a publicly-owned FHC for a family physician is only possible if she/he holds a considerable advantage concerning the number of years spent in civic duty. This process is concisely summarized by Nermin as follows:

> *"As an experienced medical doctor, I had a chance to choose a place owned by the municipality back when we switched to this system. This point is critical for many of us as your monthly allowance for taking care of the place doesn't reflect the amount you pay for the rent. Therefore, working in a public building becomes a top priority."*

Her statement constitutes an excellent example to underline the economized nature of workplace choice for family physicians and the market-like dynamics where a choice concerning the workplace is considered to be a source of extra income, rendering this choice part of a strategic decision making where a higher return on investment is made possible if one is experienced and lucky enough to be qualified for working in a publicly-owned FHC. Nevertheless, as Nermin also underscores, only a tiny portion of the family physicians may profit from the advantages provided by working in a publicly-owned FHC. However, many others should suffer the consequences of higher rents caused by working in privately-owned FHCs.

For them, the conditions are precisely the same for other private business owners concerning finding a suitable workplace in the changing dynamics of a fluctuating property market. This may result in suffering some of the unwanted side effects for family physicians. Opening an HFC, owned either publicly or privately, requires fulfilling some spatial requirements that may not be necessary for other private business owners. In that respect, the hardships of finding a convenient space sheltering an FHC is strikingly expressed by Tuğçe, herself working in privately-owned FHC, when she said:

> "*Our current building is located in an industrial park. We have to admit that it's not appropriate for an FHC (…) However, when you look for a place, some criteria are to be filled. It needs to provide a sizeable space as it has to accommodate certain facilities. But, it also shouldn't cost too much as you are entitled to a fixed monthly allowance that doesn't reflect your rent. All things combined, you should make a calculated choice meeting all of these criteria, and sometimes you may have to fit into a choice that is less than ideal."*

This quote perfectly illustrates how the pressures of acting on a fixed budget frame the choices and decisions of family physicians at the very first stage when finding the proper place for an FHC is in question. This unequal distribution of rent load between family physicians is reflected concerning the differences between

working in a publicly or privately owned building. The fluctuating prices of the property market that may vary immensely according to the location and neighborhood where one will be employed is also another factor shaping this choice for primary health care professionals. As stated by a handful of the participants, some vacant positions cannot be filled mainly because of the excessive rent prices demanded for the upmarket locations in the city. This stands out as one of the negative side-effects of the current system tied to the introduction of rational choice regarding family physicians' choice of workplace from the standpoint of public health.

Even though the issue of rent appears as the predominant financial liability on the side of family physicians, there are other spatial requirements to be met by them in the current model. In that respect, the financial load triggered by the monthly bills should be addressed more thoroughly. "Saving" is the key concept regarding this subject, and it is a predominant discourse in nearly all of participants' narratives as a way to manage the place. Zeki, a family physician in his mid-thirties working in Esenler district in Istanbul, aptly explains this point, when he says, "*It is not hard to claim that we work as a private health institution and when profit is a primary concern, "saving" becomes a major priority automatically for you.*"

Based on his narrative, acknowledging the system's share in molding a particular kind of behavior in oneself and choosing to embrace it instead of developing some sort of resistance can be considered proof of neoliberal subjectivity formation, per se. In his statement, this monthly allowance granted to family physicians for the management of the place is not seen as an amount of money to be fully invested for maintaining the workplace intact, but a source of potential income where the excess should be kept as some sort of a reward for a wisely spent financial source at the end of the month.

However, this potential source of extra added income to a family physician's salary is not acquired without any friction. A family physician should also persuade others for their motivations as they are not working in an isolated environment but encircled with other people. Yet, this persuading effort may risk instigating further

disputes between co-workers in the FHC as subjects may hold little or no incentive for saving or may simply not care as much about the monetary benefits of saving. These possibilities are exemplified by a statement in this section that will be elaborated on below. Veli's words are not only indicative of the potential of a further dispute between co-workers in FHCs concerning their propensity for saving, but it also reveals how work relations have been framed by the consequences caused by individual actions implying financial results.

> *"You always look for different ways of reducing your costs. However, this may raise tension between your co-workers. For example, our FHC isn't easily heated during the winters, and we may have to use electric heaters when necessary. When I see one of them not turned off when one of my fellows is not in their room, I kindly warn them saying that they should turn it off once they leave the room. Some of them appreciate my concern, but we may dispute with some others occasionally. Well, nothing to do about it because, but there is no place for irresponsiveness in this system."*

His narrative on overcoming others' *'irresponsive'* attitude points to the transformative potential of neoliberal responsibilization. As is stated by Scharff (2015), neoliberal subject operates through a process of boundary-making in a way that justifies his/her actions while blaming others. Veli, while defending his actions, chooses to blame others' subjective positions that do not pay as much attention as he does, and that way, he also tends to embrace his calculating-self.

However, overcoming others' reluctance to accommodate themselves with the required subjective modulations that would yield a positive financial result to their income is not enough on its own to secure this surplus income. As it would be detailed below, a significant amount of time should be devoted to researching how one can procure the consumable materials the cheapest way possible out of a given budget. Thus, the mentality of saving not only applies to an effort concerning a reduction in the bills but also another expense such as consumables. Canan, a family physician in her late thirties, working in the Şişli district in Istanbul, illuminates this tendency when

she stated that family physicians should devote a significant portion of their effort to supply the everyday necessities at the lowest price possible. She underscored that achieving this task may sometimes even take a full day's work. Besides finding the most affordable price, deciding the optimal amount is as crucial as they work on a tight budget and do not have a chance to supply in excess to make ends meet at the end of the month.

Her narrative can be multiplied and reflects the significance of rational decision-making for the family physicians and the economization of their selves through the standard requirements of the place that need to be supplied regularly to ensure that the site could function as a primary health care facility without any problem. As a result, it is possible to delineate the priority to save money in handling every task that requires a monetary transaction in the current state of affairs. This economized approach can trespass the boundaries of everyday necessities and impact other decisions, too. In that regard, it is vital to look at how seemingly minor activities in the workplace may be framed in economizing terms by the study participants. Two examples are of particular interest, here, to understand what is at stake concerning this point. The first one of these comes from Celil when he pointedly illustrates a tension-driven encounter with one of his co-workers concerning the supply of bottled drinking water. "*We would buy the dispenser size water the other day. We use it for brewing tea here and usually prefer plastic bottles. But one of our friends asserted that we should go for glass bottles instead, because they were healthier. We objected that because they were much more expensive than the standard option."*

In another example, Halide, a family physician in her early-forties working in Fatih district in İstanbul, narrates how coffee consumption could be framed as an expense to be regulated to communicate how the minute details can become a subject of heated discussion in the FHC. As she highlighted during the interview, they opted for buying a coffee machine as everyone liked drinking coffee for the place. In the beginning, it was a unanimous decision, as it simplified the enjoyment of a commonly-shared pleasure considerably. However, the augmented joy driven by acquiring the coffee machine was relatively short-lived. "*After buying it, we started to notice that*

the coffee consumption dramatically raised because it is much easier and quicker now to make coffee. We think of setting a daily quota now if this increase in the coffee consumption goes on," she said, with a pretty alarmed tone in her voice.

These two examples constitute a shared ground for reevaluating the consumption of pleasure-inducing substances such as tea and coffee in the workplace. They are crucial in demonstrating that even the everyday pleasures in the workplace can cause disagreement as the principle of responsible use for such materials is well-established, now. Their consumption is no longer for the sheer pleasure derived from consuming these goods but subject to a strict economized framing, where their use should be regulated and limited to a certain amount. Thus, it is possible to observe the different effects of neoliberal responsibilization to penetrate even one's daily habits at this point, that have not been thought in market terms so far.

The tension based upon saving money may also affect the way family physicians treat the patients visiting the place. As this model structures the primary healthcare in a way where family physicians are only responsible for taking care of a specific population that has been registered to them, the treatment of guest patients appears as a problem for most physicians. This point will be further elaborated in upcoming chapters while tackling how neoliberal subjectification is reflected in the relationship between a family physician and the patient. Though, the matter to be emphasized here concerning the spatial responsibilization is the way a family physician, Halide, defended her stance for not taking care of a guest patient in an example when she said:

> *"One day, a guest patient visited me and asked if I can do an injection. "No!" I said and declined her request because she wasn't my patient. If I injected her on her request, that would have meant that I wouldn't have injected another patient of mine, and I didn't want this because my medical supply was limited."*

Her argument based on the insufficiency of the available medical supply that is *'just'* enough for her *'registered'* patients is further proof emphasizing how neoliberal responsibilization infiltrates the subjectivities of the family physicians. This example

is particularly poignant as it demonstrates the intersection of spatial responsibilization manifested in the prudent use of available financial and material resources with the responsibilization towards one's registered patients in this system. When Halide expresses the reason for her inability to do an injection to the guest patient, it is implied that she is not only financially responsibilized to stay in a given budget and possibly make a profit out of it, but also to prioritize the well-being of her registered population over other possible guest patients visiting the place. As clarified by this example, the actions, attitudes, inter-relations, behaviors and discourses employed by the subjects that can be used as definitive proofs of the formation of a neoliberal subjectivity are not produced as a result of a simple causal chain, but structured as the consequence of a complex mechanism most of the time.

The final point concerning how the responsibilization for supplying consumables affect the subjectivity of family physicians is what I would like to ironically call *'the toilet paper myth.'* Nearly all of the participants in this study complained about how the fulfillment of their spatial responsibilities constitute a significant burden on their shoulders. However, the "toilet paper myth" is an expression that I came up with for formulating the lowest point in handling these tasks that should be avoided at all costs. Most respondents stated that in some cases, even toilet paper consumption is subject to regulation as it was a significant expense. However, none of them except one participant has agreed to admit doing that as they framed it to be derogatory. Gizem, a family physician in her mid-thirties in one of the upscale neighborhoods of Sarıyer district in Istanbul, grounded her argument on the necessity of delimiting the toilet paper consumption as stated below:

> *"We have to regulate the toilet paper consumption in the place as we have a crazy rent to pay because our FHC is situated in one of the most expensive neighborhoods in the city. That's why we decided to limit it to one roll per month for each personnel, and this way, we can barely make ends meet."*

The first thing that strikes the eye concerning her statement is the defensive tone dominating her speech. She was probably aware that this act is interpreted as a

caricaturized culmination for all the evils of the FHC system and the spatial responsibilization that comes along. However, one point that should not be missed among her self-redemptive discourse is her pointing towards the rent as direct a link connecting us to the beginning of this section and a timely reminder as one should not evaluate these responsibilities in isolation from one another. On the contrary, the "myth of toilet paper" and Gizem's narrative is further proof of the potency of neoliberal subjectification in shaping the actions and everyday behavior of family physicians, compelling them to interpret the majority of their actions as the sum of an imbricated self-calculative process where a choice always results in a new set of options that constitute a given field of action for the subjects to create their path. However, each one of those actions sets a boundary for one another as they are posited on the same plain and in that way, forcing them to be prudent about the consequences of their choices as each one of them affects another in unforeseeable ways.

2.5. The Co-Responsibilization of the Family Physicians and the Thwarted Autonomy: *"I like it when things go the way I want them to be. Mostly, you have to fight for your choices to be implemented, though!"*

The subjectivities of family physicians in the current spatial regime of FHCs have been evaluated along the lines of responsibilization and the economization of their selves so far. However, a careful rereading between the lines also reveals another central dynamic of neoliberalization. A critical evaluation of the materials derived from the interviews conducted with the participants indicates that both further responsibilization of a family physician through the spatial reorganization of FHCs and the calculating-self that appears as a significant consequence when one tries to handle managerial responsibilities is rendered possible within a discursive field where the freedom formulated as freedom to choose is prioritized as the prerequisite of family physicians' current subjective conditions. Both the economization of the self and the responsibilization of family physicians is predicated upon and justified within the boundaries of a discourse identifying the subject free in her/his choices. In that regard, an active subject is defined as a *sine-qua-non* precondition for the family physician.

The primordial connotation carried by the concept of "active subject" can be formulated as “autonomy.” When the subjective condition of family physicians has been evaluated from afar and assessed in terms of how it has been defined and structured within the current legislation that regulates the duties and responsibilities of the FHC, it is easy to be mistaken that a high level of autonomy and a wide field of freedom is granted to family physicians. The transition from a strict civil servant ethos towards a more managerial role where a wide variety of instruments is identified can be interpreted as the book definition of the creation of an active subject. However, when we take a closer look through the different mechanisms where this novel subject structured, the picture becomes more and more complicated, and it can be rightfully argued that the limitations faced by this subject start to be more visibly observed.

The first aspect to be talked about in that respect is emphasizing a particular characteristic of family physicians’ responsibilization. This process is mostly addressed in individual terms so far. The various responsibilities that had to be undertaken by family physicians have been framed in isolation from the respective responsibilization of each participant. However, it is of significant use at that point to emphasize that the responsibilization of family physicians working in an FHC operates in a co-responsibilizing dynamic. The fact that various spatial responsibilities have been mutually owned by family physicians working in an FHC constitutes the primary source of contention for the participants as every minor task and every decision-making process in the current situation carries the potential for the formation of a battleground for medical doctors.

At this point, departing from a participant's narrative seems the most obvious choice as it enables us to make better sense of how the co-responsibilization operates as a limiting mechanism to one's freedom of choice. To explain that, Zeki gives an example where he shares an anecdote about buying a new refrigerator to protect the cold chain for keeping the vaccines safe and secure in ideal conditions. Protection of the vaccines is one of the top priorities for all family physicians as they are directly held responsible for any malfunction rooted in not being able to keep them safe at certain temperature intervals. During this process, Zeki and a group of co-workers

opted to buy a device specifically customized for this task. However, as it cost considerably higher in comparison with a typical refrigerator, an opposing group of family physicians objects to this choice as this would mean a higher cut from their monthly allowances. This polarization based upon choosing the right refrigerator escalated as time goes by. It could be resolved only when they could agree with purchasing a customized but lower-priced product. Zeki complains about the perpetuation of this process in every task that needs to be decided in common terms, and the level of compromise one should make to reflect one's individual preferences to the management of the place. *"I like how this system gives us the flexibility to act according to our own needs concerning our physical liabilities. Mostly, you have to fight for your choices to be implemented, though,"* he said when he tried to explain the shortcomings of the current system from his point of view.

His narrative presents a common grievance that is more or less present in each participant in this study. In most cases, fulfillment of a spatial responsibility is achieved after a lengthy process involving a heated discussion, presentation of personal arguments, respective efforts to persuade each other and formation of strategic alliances to create a pressure group concerning the decision. Most of the time the process results in a halfhearted compromise that does not satisfy any party participating in the process completely. In that respect, this negotiation plays out as a limiting mechanism to the freedom of choice for family physicians and curb their autonomy significantly.

A specific sub-group within family physicians that should be mentioned concerning this point is the executive physicians. Their narratives might be where the level of complaint is articulated at its loudest. Ilkay is a former family physician in his late thirties who worked as an executive physician for six years in an FHC in Şişli district in Istanbul. After resigning about a year ago, he currently lives in London and tries to pass the necessary examinations that one needs to undertake to be able to work there as a medical doctor. When asked about the significant motivations that led him to look for his future elsewhere as a medical doctor, one of the fundamental reasons he grounded his decision was the lack of a clearly defined authority as an executive

physician to implement his choices that, he thought, would benefit the FHC. He delineated the role of family physicians within the current spatial governance of the FHCs as *"all about responsibility but nothing about authority*."

Ilkay had a two-year-long vocational training in the field of health management in addition to his medical education, and as he underlined with an frustrated tone in his speech, he was excited to channel what he learned from that to his position as an executive physician. However, things have not evolved the way he predicted initially, and he stated that he found himself in a position where he had to suffer all the burdens of being an executive physician but could not make a meaningful change at the end of the day. Even though he appreciated the current system on paper as it promised a break from the strict bureaucracy for medical doctors, he strongly emphasized that the real-life implementation of this system was far short of delivering its initial promises. *"Peer-sabotage and the principle of unanimity over the decisions take over the place of bureaucracy in this system, and no substantial change occurs in the end,"* he claimed with a somewhat disillusioned way.

The obstacles posed to one's individual freedom of choice and autonomy by other colleagues is a reiterated theme encountered repeatedly during the interviews. However, maybe its most extreme form has been expressed by Selim. In his mid-forties, he is a family physician working in one of the wealthiest neighborhoods in Istanbul in the Kadıköy district. He is easily distinguishable among other participants as he seems to embrace the transition to the FHC system in earnest. When he exemplified his grievance about the limitations set by other colleagues to his freedom in allusion to one of his friends who works as the owner of a dental clinic, he strongly criticized the shortcomings of the FHC system from his point of view in a rather striking fashion.

> "*Recently, I have visited a friend of mine's dental clinic. It was refurbished by an interior architect and had an exquisite environment. I thought that maybe we should do the same as this system gives us this opportunity on paper. However, family physicians should work alone as single unit workplaces, as is*

the case in its Western counterparts. Because when you have colleagues that don't share your vision about this system, you are bound to their will in crucial moments. If that wasn't the case here, we could provide top-notch health service to our patients in a high-quality environment, and our patients could discern the difference and make their choices accordingly."

As his narrative clearly implies, the frustration grounded on the co-responsibilization of family physicians that stipulates a commonly agreed compromise and the principle of unanimity in most of the decisions concerning the management of the place as it is articulated by other participants as well may reach a point where one wants to work as a single-unit FHC that it is possible the high level of freedom that would be experienced by working at one's own terms. It is an extreme example showing that the practical impossibility of working alone strictly limits the level of independence for family physicians. Even though single-unit FHCs are an existing reality in Turkey's current primary health care system, its viability is highly limited by practical reasons that will be touched upon in the upcoming chapter.

Selim's narrative obliges us to look for how the spatial reorganization of the FHCs has been achieved during the transition from the replacing CHC model to make better sense of how this limited freedom of family physicians took shape in the first place. Since it is rather apparent that the agencies of family physicians in Turkey are seriously limited, it does not explain how such a system took shape in the first place on its own. At this point, looking at how the spatial governance of an FHC is organized within the space takes precedence over examining the individual complaints about the system's running. As mentioned in the preceding sections, the spatial responsibilities undertaken by family physicians in this system are compensated with the monthly allowance allocated to each family physician accordingly to her/his classification. For each FHC currently operational in Turkey, the State has identified a common space where the responsibilities have to be dealt with jointly by family physicians. Fixed costs such as the rent, the bills, the staff payment, the commonly shared medical equipment are typically treated as obligatory components of this shared space and equally shared by every family physician working in the FHC at the end of the month.

However, apart from that shared space, a private area has also been identified, and the real problem starts here for the family physicians.

The distinction between the private and the common space in an FHC is left to the family physicians. The definition of private space generally includes the responsibilization for one's personal space such as supplying personal medical equipment and consumables such as surgical masks, injectors, the medical glove, etc.; providing the technological equipment in one's room such as personal computers and printers; decorating one's room and so on. However, in many FHCs, these responsibilities are also included in the definition of common space as maximization of the level of co-responsibility provides a more cost-effective result most of the time and increase the probability of yielding a more substantial additional income for each family physician. A more broadly defined private space nevertheless results in more autonomy and grants family physicians more freedom in their actions.

This creates a dilemma where family physicians have to choose between greater autonomy and agency in their actions rooted in a more broadly defined private space and a greater monetary return based on the financial efficiency derived by a more broadly defined common area. This unavoidably results in the formation of varying spatial governance in FHCs all around Turkey, granting a varying degree of freedom to family physicians. *"The number of different models in this system is equated with the number of FHCs in Turkey*," says a participant to emphasize the level of diversification concerning the spatial governance of the FHCs.

This also points to the hybrid nature of the system, where the remnants of the CHC model are still observable. Most of the FHCs currently operating in the country are based on a spatial model that obliges family physicians to work in multi-unit FHCs. If the single-unit FHC model could have prevailed, the contentious dynamic between common and private spaces may have ever occurred at all. Because in a single-unit FHC, there is no such distinction such as a personal and a common area as a family physician is responsibilized for all the managerial tasks and liabilities, and she/he is free to act the way/he pleases. However, family physicians in Turkey should bear with

the limitations concerning their freedom of choice as they are co-responsibilized alongside their colleagues to run the FHC. The distinction between the private and the shared space is born out of necessity when the multi-unit structure of CHCs is mainly left intact. However, as the FHC model anticipated a single-unit spatial structuring as the standard model elsewhere since the very beginning, this temporary solution in the form of distinguishing between the common and the private space of family physicians to ensure the viability of multi-unit FHCs cause more problem than it solves as nearly all of the participants indicates. Aside from curbing family physicians' autonomy, such a distinction also instigates the development of animosity towards each other and threatens to disrupt the labor peace in the FHC.

2.6. Conclusion

During this chapter, the subjective transformations occurred on the side of family physicians through acting on the novel spatial reconfiguration dictated by the FHC model are scrutinized. The main focus of the chapter was the introduction of an extensive level of responsibilization for them to manage their workplace and its discursive correspondence in their attitudes and behaviors as captured by their own narratives. It was interesting to observe that how this elevated responsibilization is translated into a self-evident economizing discourse during the interviews, framing every task through a careful calculation if its costs. Highly resonant with the self-entrepreneurial discourse imminent within the neoliberal subjectification, the enjoyment of a relatively increased level of autonomy is frequently mentioned for achieving managerial responsibilities.

Doing that, a theoretical approach developed by Pierre Dardot and Christian Laval(2014) has been prioritized. As they claim that *"if there is a new subject, it must be grasped in the discursive and institutional practices that engendered the figure of the man-enterprise or 'entrepreneurial subject' in the late twentieth century, by encouraging the institution of a mesh of sanctions, incentives and commitments whose effect was to generate new kinds of psychic functioning"* (Dardot and Laval, 2014, p.256). Because the main of the study was to make sense of the neoliberal aspects of a family physician's subjectivity through the contours of her/his professional identity,

their approach to the new subject of neoliberalism rendered possible situating the family physician as a neoliberal subject in her/his working space.

"The neo-liberal moment is characterized by a homogenization of the discourse of man around the figure of the enterprise" says Dardot and Laval(2014, p. 259) in a way resonant with the figure of family physician encountered during the interviews quite clearly. As stated above an amalgamation of sanctions and incentives enabled a field of action for family physician in this novel spatial reconfiguration to maximize their income through an efficient use of their monthly allowance. Even though a total internalization of those new spatial responsibilities was hard to observe except one or two participants who fully embraced this novel professional identity, a minimum level of economizing discourse is well-manifested in nearly all of them proving the potency of this novel spatial model.

The key mechanism to understand here to better grasp the formation of this novel subjective position is the unitarization of the subject as it is claimed by Dardot and Laval(2014). They claim that the preceding liberal subject of capitalism has been marked by a *"multiplicity internal to the subject, or the separation of spheres to which it corresponded"* (Dardot and Laval, 2014, p. 259). These spheres were defined as *"the customary and religious sphere(...); the sphere of political sovereignty; and the sphere of commodity exchange"* (Dardot and Laval, 2014, p.256) resulting in a subjective position rooted in a mixture of a multitude of those corresponding spheres that have been more or less diverse dynamics and requiring a differentiated subjective association from the individual.

We see that the multiple subject of liberal framework has been decomposed and reconfigured itself in a unitary logic based upon the enterprise model in neoliberal times. "The new figure of the subject effects an unprecedented unification of the plural forms subjectivity that liberal democracy allowed to survive" (Dardot and Laval, 2014, p. 259) they claim paving the way to *"governing beings all of whose subjectivity must be involved in the activity they are required to perform"* (Dardot and Laval, 2014, p. 259). Resulting subject of neoliberalism in that respect, is *"never reduced to the status of a passive object, as of viewing him as an active subject who must participate fully,*

commit himself utterly and engage completely in his professional activity" (Dardot and Laval, p. 260).

During the interviews, we can see how this image of active subject where the heterogenous parts of its character has been unified for the formation of a more entrepreneurial subjectivity; as varying discursive evidence derived from their narratives are quoted frequently during this chapter. The tendency pointing to an intensification of work blurring their worktime and workspace, framing leisure activities in the framework of cost-effectiveness or grounding their accelerated propensity to save money on ethical behavior for the conservation of environment or on being an exemplary civil servant benefiting both the State and themselves at the same time can be read as important clues engendering their entrepreneurial-selves, in that respect. The necessity of dealing with the managerial duties of the workplace that has not been classically defined as part of their professional identity and their resonant answer to those requirements further proves that family physicians are adopting, willingly or unwillingly, a more entrepreneurial framing of their subjective existence mobilizing their personal traits in the fulfillment of those requirements.

However, there is a certain component in that equation appearing as highly problematized by family physicians themselves and posing an obstacle to the untarnished flourishing of this neoliberal subjectivity. This is the lack of an elevated level of autonomy as a prerequisite of neoliberal subjectification. *"(...)Everyone must learn to become an 'active' and 'autonomous' subject in and through the action they must perform on themselves"* writes Dardot and Laval (2014, p. 268) to explain the primacy of a certain level of autonomy in the creation of neoliberal subject. Even though, this autonomy has been mentioned by many participants especially in their enhanced capacity to deal with the spatial requirements the way they desired, an overwhelming majority also pointed to a curbed autonomy resulting from the extensive co-responsibilization of the managerial tasks considerably limiting their field of action.

At that point, it is crucial to remember that an FHC, as the main locus where healthcare services has been provided to the citizens is not a spatial formation that has

been structured from zero but more as a replacement of the former Community Health Center model. The transition that took place from the CHC model to FHC scheme could be achieved only when some features of the preceding model has been left untouched by the State authority. The motivations behind that decision left aside, the multi-unit structure of a current FHC is mainly a remnant of CHC model and constitutes the main ground for the co-responsibilization of the family physicians to a great extent. As this co-responsibilizing tendency could be framed as the main source of frustration for the participants most of the time, as it prevents them to act on their will and limit their agency, it may be crucial here to remind the reader the main premise of actually existing neoliberalism literature. As pointed by Brenner and Theodore this literature, besides the subjective claims of Foucauldian approaches, mainly emphasize *"the contextual embeddedness of neoliberal restructuring projects insofar as they have been produced within national, regional and local contexts defined by the legacies of inherited institutional frameworks, policy regimes, regulatory practices, and political struggles"* (2012, p. 349).

Even though this study derives its explanatory framework from a Foucauldian rereading of neoliberalism, reminding the embedded character of neoliberal policies in that respect may be particularly beneficial to understand the structural reasons where the inhibited autonomy of the family physicians based upon an extensive level of co-responsibilization in conjunction to the inherited spatial framework of the CHC model. The willingness to switch into a single-unit FHC model on the side of some of the participants is none other than pointing to this aspect of the current operation of an FHC. As participants already stated during the interviews, the hardships of coping with the consequences of this co-responsibilizing mechanism, channeling family physicians to constantly enter into alliances with their colleagues to assert their will over others even may result in a further disengagement with the medical profession so far as to drag them into resignment.

Still, the inherited features of the replacing model cannot be only interpreted as resulting in a restrictive dynamic restraining the autonomy of the family physicians. In a different light, this very feature obliging them to work in a co-responsibilized

scheme can also be seen as an opportunity for the participants where the common handling of managerial responsibilities and financial liabilities of the FHC instead of an individual effort provide them the chance to minimize their financial risks and managing the place in a more cost-effective way rooted in an economy of scale enabling them to amass a higher income at the end of the month as they can save further from their monthly allowances. Their narratives also prove, quite in detail, how they benefit from this even though the current spatial governance of an FHC is mostly a result of the implementation of a neoliberal policy framework built on the remnants of the old model. Even though, their autonomy has been severely restricted from the difficulties of working together in this new model, suppressing the activation of a crucial component of a neoliberal subjectivity as limiting their authority, this very feature has been reevaluated positively in a way bolstering their income and minimizing their risks compatible with the founding premises of the neoliberal subjectification approach.

-3-
NEOLIBERAL SUBJECTIFICATION THROUGH LABOR ARRANGEMENTS AND THE TRANSFORMATION OF WORK RELATIONS

3.1. Responsibilization Through The Contractualization of Labor: *"They tell us you signed a contract and you should bear with the consequences. Though I had no choice."*

The introduction of the FHC model as the standardized medium for the provision of primary healthcare in Turkey has been discussed in terms of the spatial framework. However, one point that should not be overlooked, while trying to reveal different ways the formation of a neoliberal subjectivity is based upon, is how the labor relations between the state as the employer and the family physicians as the employee has been regulated in a way rendering possible the transition towards the institutionalized definition of "family physician".

Under the old regimen of the CHC, the general practitioners working there have been classified as civil servants liable to the 657 numbered civil servants code. However, the passage from general practitionership to the family physician status transformed them into contracted laborers. Within the boundaries of the new legal regulations concerning the labor status of family physicians, each family physician should sign a two-year contract with the governorship of the respective cities where their FHC is located. This contract is renewed every two years and radically changes the ontological nature of their profession in varying aspects that will be elaborated on below.

First of all, it should be noted that the contractualization of their labor is perceived to be an individualizing catalyst for family physicians. In that respect, the contract is mainly interpreted as a mechanism serving to internalize all the responsibilities and liabilities that come with the family physician's acquired title.

While detailing his complaints concerning the high level of responsibilities, Zeki underlined how this point had been framed within the conversations with his colleagues where he complained about how they blamed him as they thought he overreacts to the level of responsibilities while referring him to the contract he signed at the beginning. *"You knew how it was going to unfold as it was written on the contract. Now, you should stop crying like a baby once you signed it!"* he told, and also underscored that he could not develop a counter-argument to this point as he thought that they were right to a certain extent.

This emphasis on the binding nature of the contract; channeling family physicians to frame its signing as an informed choice that one could have rejected also result in an internalization of those provisions to a certain degree as one's signature under the contract has been perceived as a sign of approval and Zeki's narrative constitute a telling example on that respect as he also perceives himself to be the one to blame because he agreed on signing it renouncing his right to criticize the working conditions materialized by that contract.

However, it should be noted that being a family physician is the sole option if one would like to work in the primary healthcare provision. Tuğçe objected to that aspect of the contractualized nature of their employment that neutralizes any possible resistance to the liabilities of the contract as it instigates an illusion of a conscious decision for oneself to choose among many existing options. *"As I always desired to be employed in the primary health care provision, I had no other chance but to sign it,"* says Tuğçe, condemning her inner circle on their constant criticism about her reminding that she was the one who chose to sign the contract, in the first place.

The act of signing the contract and introducing an individualized labor status does not the only factor contributing to the individualization of family physicians' working conditions. The terms and general content of the contract should also be considered while discussing the other effects of introducing a contractualized working regime. Two specific points that should be emphasized in that respect are the

differentiation of the salaries and personal benefits, such as retirement and pensions, with the introduction of the contractualization of labor.

Varying employment statuses have been established within the FHC model enabled by the contractualization of family physician status. A significant portion of the medical doctors working in the FHCs sign their contracts as civil servants in this system and move into family physician positions without losing their rights resulting from their current civil servant status. When they leave the system, they are appointed to other sections of the healthcare provision by the State due to their protected civil servant status and do not have to face the consequences of a potential job loss. These individuals are also paid a higher salary due to their status, compared to the family physicians who come from the private sector and do not carry the title of a civil servant. This group is simply treated as any other contracted labor by the state. If they decide to leave the system or their contracts are not renewed by the respective governorship, they should go back to the labor market and face the consequences of unemployment instead of their colleagues adorned with the privileges of civil servant status. This group is also treated in unequal terms concerning personal rights as they are deprived of higher-rated insurance premiums determined for their colleagues on civil servant status that translates into both higher pensions and the chance of earlier retirement.

This creates an environment where differentiated labor agreements are in place for family physicians under the roof of an FHC. The lack of a uniform working regime treating every medical doctor differently deprives them of comparing and discussing their salaries and rights on the same plain. In that respect, the working regime in an FHC is regulated more or less in the same vein as private sector, where a fragmented work scheme is determined as the *status quo*. The lack of any meaningful comparison for family physicians concerning their salaries and personal rights results in them feeling more isolated, as is also highlighted by the participants during the interviews.

Asım was vocal about this sense of isolation and elevated the significance of a higher level of individualization emanated from that during our interview. *"I stopped questioning after a while why I am getting paid a certain amount when some of my*

colleagues are earning a much higher sum at the end of the month," he said in an easily palpable sense of frustration in his narrative and also complained about the reluctance of other medical doctors to discuss their salaries and personal rights adding: *"I think we should be able to talk freely about the discrepancies concerning these issues, but this place doesn't feel any other private health institution in that respect as they mute the moment you bring up those subjects to the table."* He is not alone in his discontent towards feeling isolated in the workplace due to this fragmented working regime. However, to be able to make better sense of how the contractualization of labor operates for family physicians in a way rendering them more isolated subjects, one should also look at the temporary nature of their work.

In the face of this limited labor contract, the least disadvantaged group is once again the medical doctors, who are classified as civil servants. However, the situation seems bleaker for others whose employment security is strictly based upon their agreement with the State. The continuation of the contract is conditioned to the fulfillment of two significant criteria by the family physicians. The first one is securing a particular population during their work as each medical doctor is responsibilized for having at least 1000 registered patients under their name as long as they are employed. If this number falls below that threshold for two consecutive months, the respective governorship holds the authority for the unilateral cancellation of the working arrangement.

This is not a concern for those who have a chance to be appointed to an existing family health unit that already contains a portfolio of patients well above 1000. Especially in crowded metropoles such as Istanbul, that is not a significant concern for most family physicians as an overwhelming majority complains about not for the lack but an excess of registered patients causing a considerable drop in the quality of medical service provided to those patients. However, there is a sub-group between them whose situation should be evaluated specifically for that matter. These are medical doctors appointed to either a virtual FHC or a new Family Health Unit in an existing FHC. They experience the threshold of 1,000 registered patients as a real threat to the continuation of their positions as family physicians. Those appointed to

these positions should start from scratch as they have zero patients at the beginning. If they fail at reaching the threshold of 1,000 after a year from their first day in the work, their contract has been automatically canceled by the State. Many participants have highlighted the precarity of their working conditions during the interviews. Even though there was only one participant in the sample who experienced the difficulties of working in a unit with a non-existing population in place, it was commonly agreed that those individuals are the ones who suffer the most from the consequences of that obligation.

For those appointed to an additional unit within an existing FHC, the situation is slightly brighter as the other family physicians could help their colleagues reach that number by giving up a portion of their patients to their co-workers. However, the courtesy of their colleagues is not guaranteed for them as this is left entirely to the goodwill of other family physicians. *"I know lots of places where doctors don't want to give up their patients to the newcomers as it would affect their salaries negatively at the end of the month,"* states Aynur, a family physician who was lucky enough to have the support of their co-workers in a similar situation and clarifies the primary motivation for the reluctance of other family physicians to do such a favor to their co-workers.

Her narrative reflects the significance of the registered number of patients as the primary measure of a family physician's salary. This results in the treatment of one's population as a financial asset in most cases. This point will be further evaluated during the next chapter when the subjective transformation of family physicians will be assessed concerning their relationship with the patients. However, this does not change the fact that the unreliable nature of this courtesy on the side of other family physicians is a major contributing factor to the sense of insecurity experienced by those who should start from zero. The ones who undergo the same situation in a virtual FHC are definitely in a darker place as they do not have the help of any other co-worker to reach that number. "*I have two friends who have been appointed to virtual FHCs with a zero population. Both of them left their job before the completion of one year as they*

understood that it was impossible for them to reach the magic number 1000," Canan said to highlight the difficulty of the task.

The second criteria regarding guaranteeing the continuation of the family physicians' labor contracts is avoiding any kind of misconduct identified by the disciplinary regulations. Their breach has corresponded to a certain amount of penalty points under the current system in proportion to the severity of the alleged misconduct. Five penalty points are fined for a minor violation of the disciplinary regulations such as getting late to work as a much severe violation such as getting to work drunk is fined by a whopping 50 points. If the total penalty points earned within a year of work is equaled or surpasses 200, the State holds the power of unilateral cancellation of the labor contract again. Most participants in the study pointed that getting to that point is a rare occurrence in the current system. *"You should make a mammoth effort to be fired for that. It's only possible if you're late to work every single day or commit major errors such as getting to work drunk or forge a false medical report,"* says Nermin, to illustrate the situation for the researcher. However, the chief opposition concerning the penalty point system centers on two related points to be discussed more in detail.

First of all, a significant portion of the participants is uncomfortable with the main logic of this practice as it involves the quantification of acceptable and non-acceptable behaviors within the workplace and therefore quantifying the ethical principles of the medical profession. *"The numbers are everywhere in this system. Whatever you do, you earn or lose points, and the outcome of how you perform your profession is measured that way. It is disconcerting for me to be graded in every aspect of my job*," states Melda, in a rather angry tone expressing her discontent for the current disciplinary regulations that reduce the deontological principles of the medical profession evolved within a centuries-old medical profession to a *"game of numbers"* in her own words. However, the process of quantification is highly resonant with the principles of neoliberal subjectification as a similar logic can be found in every part of the business world and more and more in the public sector as this example also suggest pretty self-evidently.

The second major disturbance regarding that is the abusive potential of this practice by the State to impose an unwanted aspect of the FHC model. A strong illustration of such abuse can be found in Ahmet's statement when he detailed such an example as follows:

> *"It was around 2014, if I'm not wrong. They wanted us to work during weekends in addition to our standard shift. We refused that and didn't show up for work on the weekend. During that period, they tried to use this penalty point system against us. However, we were large in number, and in the end, they understood if they exterminate all of our contracts, the system would have collapsed, and we won. They fired some of our colleagues during that to scare us, but we didn't give up, and it paid off in the end. Our friends who lost their jobs also got back to their positions. Even though it was a clear victory for us, it is enough for me to prove that they are ready for abusing such properties of the system.*

His anecdote is telling in at least two respect that should be mentioned here. First of all, it shows the State's tendency to mobilize this disciplinary regulation as a crucial instrument for the creation of more governable subjects in a resonant manner with the principles of the neoliberal subjectification. However, maybe, more importantly, this narrative is a powerful example pointing to an imminent potential to resist the effects of the system by family physicians. Even though not planned as an organized strike, the family physicians managed to counter the imposition of the extra weekend shift by the State as a result of their passive resistance. Though, one should be cautious enough to claim the inherent potential for the resistance embedded in this system. Melda, while reflecting on the same event, arrives at a different conclusion that should be mentioned here:

> *"We were able to get what we wanted back then because we were a scarce resource for the State. However, more medical schools are opening every year, and more young doctors are graduated. If they decide that this number reached a certain threshold where we become more disposable , we may encounter much worse atrocities, I fear."*

The way she emphasized how this provisional victory should not be overstated formulates a strong hypothesis that needs to be followed in the forthcoming years as it is possible for the system to reach a saturation point concerning the number of family physicians as there is still a significant shortage of medical doctors in Turkey. However, another point that should not be missed in her argument can be found in how she formulated her statement. Using the primary language of economics while treating the former situation of family physicians as a *"scarce commodity"* in parallel with market terms and talking about the imminent threat of an overflow of freshly-graduated young medical doctors giving the State to treat family physicians as "disposable," she unwittingly builds her criticism within the discourse of economics. This hints at the potency of the neoliberal subjectification as a fundamental market dynamic based on the law of supply and demand principle is directly employed by a participant while discussing the possibility of resistance within this system, quite ironically.

3.2. Family Physician as Employer: *"One shouldn't use their employees for handling their personal affairs, but many of us do, unfortunately!"*

The contractualized labor regime is one of the primary frameworks when one would like to discuss the novelties brought by the FHC model. Within the boundaries of the current primary health care provision scheme, family physicians are also held responsible for employing the necessary auxiliary workforce for managing the place in this novel regime. In that respect, it results in forming a dual status for family physicians, identifying them as both employees in the eyes of the State and as an employer for their auxiliary medical staff.

Each family physician is responsibilized for employing a certain amount of personnel in the current system of FHC, as the boundaries of this responsibility are marked by their respective class in that they belong. All of them are held responsible for employing a cleaning personnel for ten hours per week, first of all. In addition to that, the family physicians classified between class-C and class-A should employ an

additional auxiliary personnel, be it a nurse, a midwife, a health technician, or a medical secretary. They are free to choose between one of these categories according to their needs, and the time limit is identified also as ten hours per week. Finally, the family physicians whose family health unit has been categorized as class-A should hire one more auxiliary personnel, ten hours per week once again, belonging to one of the categories mentioned above. As a result, a family physician whose category is identified as class-A, for instance, has been responsibilized for employing three separate employees for thirty hours per week in total. On the other end of the spectrum, a family physician categorized as class-E should use one personnel for ten hours per week.

This obligation to employ a certain number of auxiliary personnel has been taken care of in two possible ways by family physicians. The first option involves direct employment of these staff by family physicians themselves and requires assuming direct responsibility for those employees, including paying their salaries, insurance premiums, working with an accountant to handle financial affairs, and so on. However, there is a second option where the employment has been delegated to a subcontractor where the family physicians pay a certain fee to those companies to provide them the required workforce at the end of each month.

During the interviews, I asked each of the participants how they currently handle this responsibility. Even though it does not present generalizable data as I worked with a narrow group, the results of the study indicates that the number of participants who chose the direct employment of their personnel has slightly outnumbered those who chose to delegate their responsibility to a subcontractor. Selecting both options has its advantages and disadvantages elaborated by the participants in the study. However, the main dividing line between direct employment and subcontracting presents itself as a choice between personal comfort and economic concerns.

Choosing direct employment is principally grounded on economic concerns as the costs of direct employment for a family physician are slightly less than subcontracting one's responsibility to an intermediary firm. *“We opted for a*

subcontractor at first. Though we have decided to directly employ our staff after a while as it was a cheaper option," says Halide, summarizing the common stance for the family physicians following the direct employment path. However, for those who decided to responsibilize a subcontractor, personal comfort was much more emphasized in general. To ground his argument for choosing that option, Veli states: *"We are working with a subcontractor, and they send us the required. You pay a little bit more than the conventional option in that case. This extra amount you pay, you pay it for your comfort and peace of mind as you don't have to think about what comes along with this responsibility".*

Both options can be interpreted in economic terms as the costs of choosing between the two are the primary determinant here. It is relatively straightforward in the narratives of the participants who chose direct employment as the lower cost of direct employments appears as the primary motivation. However, even when personal comfort is the top priority, as is the case for those who opted the subcontracting, the economized aspect of the decision-making process can be easily discerned. Veli's narrative, which frames his decision to interpret it as a transaction where you pay more for more peace of mind, is a telling example proving the extent of the economizing discourse. From another perspective, it can be said that the economization of this choice arises out of necessity for most family physicians as they have to cover all of the costs concerning the management of the place, including the employment costs out of their fixed monthly allowance.

The choice between economic concerns and personal comfort can be described as a field of action informed by the inner motivations of family physicians as this constitutes a somewhat subjective grounding for deciding between direct employment or subcontracting. However, the external constraints can be a significant determinant in that choice as much as one's inner motivations. When the profile of the family physicians who opted for subcontracting is evaluated, it can be seen that an overwhelming majority of them are those who work in public buildings. As discussed earlier, the rents for a public building are much cheaper than the cost of renting a private facility for a family physician. When other significant expenditures are also

included in that equation, a clearer picture starts to emerge to make better sense of the nature of this choice. *"I very much would like to go for subcontracting option as I am well aware of the advantages. I am working in a place where rental costs are among the highest in Istanbul, though Under those circumstances, the direct employment of my staff is not an option but a necessity that I can't escape for me to make ends meet,"* says Cansu and reminds that for a group of family physicians external constraints come in the first place as the costs of running an FHC is considerably higher.

However, it should also be stated that there are exceptions to each side of the spectrum as there exist family physicians who work in a public building and opt for direct employment and those who work in a privately owned property and choose the subcontracting option. This is a fact indicating a timely reminder in understanding that even though external constraints may hinder family physicians' capacity to choose, in the end, the personal priorities of family physicians take over in their final say. In that respect, it would be beneficial to highlight how each family physician chooses to spend the monthly allowance differently. In most cases, this fixed allowance allocated by the State is seen as a potential source of extra income as it was aforementioned in greater detail in the preceding chapter. In such a spatial regime, each responsibility, including the personnel payments, is treated more or less in equal terms by family physicians. Each expense on that list is framed within an economizing discourse. At that point, the deciding factor is a combination of the personal priorities of the family physician the optimal amount that could be saved for each item constituting their spatial responsibilities.

On the other hand, saving on personnel payments while opting for direct employment may appear as a more logical compromise than working in a warm environment during the winter, as observed in some other participants' narratives. In any case, it does not change the fact that the principal motivation for family physicians under the current spatial regime is mostly to save money . Still, personnel payments can be subject to a differing evaluation for each family physician, which makes the difference concerning the differing choices for the family physicians. The

economization of their selves and the constant tendency of self-calculation, visible in every moment when there is a choice involved, remains as a constant, though.

Another point that should be discussed concerning a family physician's employment responsibility is the tendency to take joint action with other medical doctors. As discussed earlier, each family physician is responsible for employing auxiliary personnel for at least ten hours per week. Most of the interviewees who participated in the study work in environments employing an average of 4-5 family physicians. When the requirement of hiring personnel that would work for ten hours per week, the cumulative labor time to be purchased by family physicians on aggregate terms corresponds to an average of 40 or 50 hours. When the formal obligation of a 45 hours typical work week is taken into consideration , co-employment of the respective personnel appears as a much more logical choice for family physicians working in the same place than employing their personnel separately. In most cases, the employment obligation is handled jointly by the family physicians as co-employment appears as a more cost-effective option. However, the way the study participants frame this decision concerning the co-employment of the auxiliary personnel reveals the economizing aspect of their relationships with their co-workers once again.

"You have to get along well with your friends if you want to handle this jointly. In that case, having a good relationship is not only good for your peace of mind, but also profitable in itself financially," says Ahmet in describing the benefits of having a good relationship with one's colleagues as *"profitable"* in his own words. Many other participants emphasized the significance of getting along well with one's co-workers not only for the sake of developing cordial bonds with them but also to be able to profit from the advantages of co-ownership of spatial responsibilities such as employment obligations and also stated that a work environment where there is no coherence between co-workers implies an imminent financial risk as the economy of scale implemented by the co-responsibilization of family physicians is only achieved when respective co-workers in an FHC maintain a good relationship with each other.

These remarks serve as proof of the extent of the economization of family physicians' subjective conditions crossing the boundaries of their decision-making process within the discourse of rational-choice and infiltrating their relationships in their workplace when they define the prerequisite of building cordial bonds with their co-workers in terms of profit-making. Another tendency embedded in the co-ownership of employment obligations could be observed regarding the formation of strategical thinking to measure their actions. The statement of another participant could be helpful here in getting right what is meant by strategical thinking more precisely.

Sevgi is a family physician in her mid-thirties working in an FHC in Bayrampaşa district in Istanbul, composed of six family physicians. She works in a family health unit categorized as class-B with one of her friends. However, four of the six family physicians working in the same are ranked as class-A. When asked about possible reasons for that differentiation between co-workers, the answer I got was grounded on maximizing the savings from the employment costs of a family physician categorized as class-A. As explained at the beginning of that section, class-A units should employ one more personnel and their existing employment liabilities. In the case of where she worked, the existence of six family physicians categorized as class-A would translate into a requirement of purchasing 60 hours equivalent of labor time in total surpassing the 45 hours limit of a typical work week that would result in the necessity to employ one more personnel in excess.

When they discussed how they could avoid that, they have decided that two of them should go for a class-B family health unit. She highlighted that they carefully calculated how the costs would be allocated according to the monthly allowance for their classification. As a result of this arrangement, they could be able to both escape the additional cost of employing extra personnel and also Sevgi and her other colleague are not affected by a lower classification resulting in a lower monthly allowance due to the proportionate allocation of the current costs in a way reflecting their rank. The process described by her not only points to the financial advantage derived by the co-ownership of employment liabilities but also the development of an active strategy to

cope with the unwanted additional costs of an extra employee. In that respect, her narrative reveals the fact that family physicians cannot be thought of as mere victims of the system as they actively engage with what is brought by the current spatial regime and try to develop new strategies enhancing their profits.

If the discussion on how the family physicians fit into their newly earned employer status is left aside, the necessity to focus on how this new responsibility is perceived in their everyday experiences becomes evident. First of all, it should be highlighted that most of the participants seem somewhat satisfied with the consequences of the delegation of employment liabilities manifesting itself in a comparative discourse where the former CHC model has been employed as a reference point. *“In the old system, you couldn’t get something done to the staff as they were employed by the State and weren’t accountable to you in their actions. As they’re our employees now, they are much more responsive to our instructions as they know that we are the ones who decide at the end of the day who goes and who is here to stay,"* says Selim, drawing attention to the newly acquired sanctioning authority of the family physicians that was remarkably absent in the CHC model. Creating a legitimate employee-employer relation between those parties leveraged the authority of family physicians regarding their auxiliary staff in a visible way resulting in an easily discernable satisfaction among them.

Still, it should also be highlighted that this overwhelmingly positive attitude is not left without reservations. First of all, most participants commonly accept that the employer status granted to a family physician runs the risk of abusing the power asymmetry rooted in the very nature of the employee-employer relationship. *"I know colleagues that have their personal affairs done by the auxiliary staff as that's not included at all in their job description,"* says Ahmet when he points to a commonly expressed attitude. Varying behaviors such as mobbing, verbal and physical harassment, and even sexual harassment are counted among other possible abusive conduct by the participants towards their extra staff.

Ahmet also mentioned another aspect concerning family physicians' being an employer in their workplace as he was highly disturbed by the delegation of employment liabilities to the family physicians manifesting itself what can be described as the *"employer-employee dilemma"* in his words. When asked about his personal experience on becoming an employer, he responded: *"I feel confused by it. Sometimes I ask myself repeatedly: 'Am I an employer? Or am I an employee?'. I don't know if there is any other working group in the world experiencing both simultaneously, but that's the case with us. I am the employee for the state, but also I am the employer of my staff"*. It should also be stated that Ahmet was not alone in his confusion as various other participants pointed to this dilemma in one way or the other. In that respect, one has to admit that the frustration rooted in this confusing experience is translated into a feeling of nostalgia; especially among the more experienced participants of the study as they spent a considerable amount of time under the old spatial governance of CHC model.

Yıldırım, an experienced family physician in his early-fifties and who works in an FHC in the south-eastern city of Diyarbakır, also mentioned his alienation towards the profession when he had to undertake the obligations of the employer status. *"I feel truly embarrassed at the end of each year as we have to discuss the next year's salaries with our personnel. I miss the old days when we worked as a team in coherence with each other and more or less equal terms. Money didn't get in the way at all back then. We had real teamwork as it is hard to catch even a pale glimpse of the beauty of those days,"* he said to emphasize the economizing nature of their relationship with the auxiliary medical staff and a visibly clear nostalgic tone evident in his narrative and his trembling voice and manifested in his faraway looks even discernable through a computer screen.

3.3. Negative Performance as a Technology of Government: *"I am much more than those numbers indicate, but the current administration completely overlooks these."*

One of the major novelties brought by the new labor conditions based upon the FHC model is introducing negative performance measures as a self-evaluative mechanism for family physicians. One of the main pillars of the FHC model, negative performance, is a primary mechanism employed to regulate the family physicians' salaries. However, before delving into how negative performance operates in the participants' daily lives and how they discursively frame it, it would be better to look into how it has been structured the way it is currently.

First of all, it should be stated that negative performance and the liability to work with a registered population cannot be thought separately for a family physician. The latter operates as the prerequisite for introducing those measures. That is rooted in the fact that those negative performance measures are valid only for certain medical services provided to family physicians' registered patients. In other words, the patients that lay outside of that registered population are not included in the performance evaluation. In the current labor regime of the family physicians, performance is defined in a way that comprises the provision of certain obstetric and pediatric services. They can be summarized as the pregnancy follow-up examinations, the vaccination of the pregnant women and children between 0-59 months, postpartum follow-up examinations, and growth monitoring of newborn children. In each of those categories, the state requires at least a 99 percent completion rate, whereas a lower rate will result in a respective cut in their salaries. Different intervals have been identified by the State descending to as far as 90 percent, where each descending interval corresponds to a higher cut for family physicians. This creates an environment where family physicians should do their best to secure the highest percentage possible for the satisfaction of this threshold in each of these respective fields as the pay cut is applied separately to each one of them.

Before moving on to the further consequences of this regulation, one should underscore that negative performance is one of the most radical novelties in the FHC model, deserving to be reviewed on its own within the boundaries of a more insightful study analyzing each element more in detail. However, as this is a study focusing on the personal consequences of the FHC model for the family physicians framed by the theoretical framework generated by the Foucauldian scholarship under the main headline of neoliberal governmentality, the points that will be addressed regarding negative performance will respect this theoretical framing.

That being the case, two axes appear as the main points of interrogation. The first one puts the State in the center and investigates how the negative performance serves as a double-edged governmental technology. This specific focus enables one to give a clear insight into how family physicians are mobilized within that mechanism to improve the population's health, targeting mainly the provision of obstetric services. The second part of the section will shift its focus on the everyday experiences of family physicians concerning the negative performance and how they (re)define their subjective conditions accordingly to that. Focusing on both macro and micro effects of the negative performance provide an opportunity to move beyond the conventional framing of this technology of government as a mere self-evaluative mechanism.

The current health policy of Turkey operates in a way drawing parallels with what is called “government at a distance” by Foucauldian scholarship (see Rose, 1999). The repercussions of this approach can also be encountered in the primary health care as individuals in a society are given a certain amount of freedom in managing their health. The introduction of the FHC system is proof that this transition in itself as a public health priority is mainly abandoned in favor of a much more individualized approach where members of a society are held responsible for keeping and, if possible, improving their health. Under these circumstances, it could be considered that the State has given up a considerable amount of its disciplinary power over the population concerning the healthcare provision and adopted a more distant place that does not directly intervene in the personal space of individuals.

However, when this view is given a closer look, it can be better understood that this distance between the State and the individuals composing a society cannot be treated in straightforward terms as acknowledging the function of family physicians in that equation is particularly crucial. The compulsion of a 99 percent rate of success for family physicians in securing some of the medical services points to a tendency where the State's distance with the individuals as a disciplinary power does not correspond to giving up its disciplinary authority, but to the delegation of some of it to the family physicians as agents acting on behalf of the State.

When the compulsory framework of negative performance evaluation is considered together with the personalization of the patient-doctor relation with the introduction of a work scheme where the family physician is held responsible for a registered population; the State's effort to redefine its distance with their citizens through the delegation of some of its disciplinary power to specific agents such as family physicians become more evident. The participants' constant emphasis on the changing nature of their job definition throughout the study in a way where a bureaucratized civil servant mentality reflecting that distance between the State and its subjects is mainly abandoned for creating a more active family physician role can be seen in a new light when they are treated as the agents of the State.

An anecdote shared by Ahmet strikingly alludes to that aspect. His narrative centers on a heated argument with a patient when he tried to convince him for the vaccination of his newborn child . *"He started to yell at me after a certain point. 'Who says I have to vaccinate my child?' he was screaming. 'The State,' I replied calmly, hoping that this may convince him but even more angry than ever, he continued yelling. 'You are a liar!' he said repeatedly, 'It's not the State, but you! You better show me the document if it's the State!'. As his demeanor became more and more threatening, I gave up after a certain moment and made him sign the vaccine rejection document and let him go,"* he said. The similar experiences pointing to the formation of an antagonistic relationship between family physicians and the patients were repeatedly present during the interviews and exhibits further proof in supporting that how the position of family physician has been perceived negatively by the patient as

an agent imposing certain medical practices where the physician, not the State has been held responsible. However, the partial delegation of the State's disciplinary authority to the family physicians does not end here.

Responsibilizing family physicians within the framework of negative performance evaluation has far-reaching outcomes beyond allowing the State to distance itself from the population and resulting in a softening in the perception of its self-imposing image. The family physicians are also responsibilized for documenting the members of the population who avoid these services or who cannot be reached by the family physicians at all. Suppose the relevant person has been consulted by another medical doctor in a private health institution, for example, instead of her/his family physician for the services that have been officially appointed to them. In that case, they have to demand an official statement from the respective institution to ensure they have finalized the required services. When family physicians cannot reach a patient or when a patient rejects the medical services provided to them, they are charged to find their patients in their homes and make them sign a document that they voluntarily reject those services. If the registered patient cannot be found in her/his officially declared address, they also have to talk to the neighbors or the neighborhood mukhtar to ensure that the respective patient does not reside in that location anymore and has got to take their signed statement approving this.

All of these required procedures for family physicians where they have to procure those documents if they would like to avoid a resultant loss on their incomes secures the collection of an aggregate statistical data strengthening the disciplinary authority of the State through family physicians. First of all, the State is notified about the exact number of individuals who have refused to take those services with their names. It also gives the State awareness of the number of people choosing private health institutions instead of the public health system in providing these services. Finally, the State is also notified by the possible movements of its population when family physicians document that such person does not reside in her/his registered address anymore. The participants that I interviewed are highly aware of this fact, as it can be seen in their narratives questioning those extra-medical responsibilities. An

anecdote shared by Canan detailing her effort to search for a patient in his registered address is quite telling when viewed from that perspective:

> *"One time, I had to spend more than half of my day to document that a registered patient does not live in his declared address. In the end, I was pissed, and I called the civil registry office and tasked them why they don't handle this as I had to neglect my patients waiting in the FHC while I am searching for that person. They told me it's not within their jurisdiction to make home visits, and I told myself, 'Get used to that girl! Now you're a population officer, as well!'"*

Her self-perception treating herself as a population officer alongside her medical subjectivity is clear proof that how family physicians' extending responsibilities based on the compulsory tasks they had to undertake within the borders of negative performance criteria plays out as a novel technology of government granting them a status of a quasi-state-statistician. And once again, the individuals face their personalized family physicians instead of the cold bureaucratic apparatus of the State materialized in the presence of a population officer. However, their newly defined responsibilities do not remain uncontested by the family physicians, as elaborated further here.

In that respect, it should be emphasized that all of the participants, without exception, have highly hostile feelings towards their new roles and did not abstain from condemning them quite harshly. *"I can't stand that the State treats me in a way running all sorts of errands for it. All I want from them is to let me be a doctor and taking care of my patients!"* a participant said, to share his agony rooted in the fulfillment of those responsibilities tied to the negative performance. It is also notable that an overwhelming majority of them complained about the one-sided nature of these responsibilities and offered a co-responsibilizing attitude to solve the problems experienced by it. *"Let's say I made one, two, three phone calls with the patient and invited her to the FHC for the pregnancy follow-up. As a medical doctor, my responsibility should end there. If she chooses not to come, it should be her responsibility but not mine,"* says Nermin, offering the devolution of some part of this responsibility to the patient. In another example, Halide states: *" 'If you don't want to*

get your child vaccinated, that's fine!' the State should say. 'But you are deprived of profiting from any public health service for the upcoming three months.' It should add, for example. That's the only way to take some of this burden out of our shoulders, I think".

The only alleged positive outcome arising from the negative performance evaluation is the dramatic increase of vaccination rates throughout the country, as underlined by the study participants. *"If a considerable loss of income were not on the table, most of us wouldn't insist so much on fulfilling those criteria, I should confess,"* said Tuğçe admitting that the negative performance evaluation contributes to the formation of a calculating self as the economization of certain medical duties may result in enhanced performance for them. This aspect is crucial in clarifying that the negative performance evaluation not only serves to the partial delegation of the disciplinary authority of the state but also to the economization of their subjective existence where the utilization of negative performance as an income-regulating mechanism yields an improved performance for the family physicians.

However, the same argument is challenged by other participants as the quantification of the performance and a possible cut in the salaries as a result of this instigates a professional subjectivity where other medical responsibilities could be neglected. *"I know many physicians who don't care about any other medical duties than what is required for the fulfillment of the performance criteria. One of them even told old me once 'I do the performance, and for the rest, I prescribe Parol and send them home. You see what I mean here?"* Halide said, pointing to the fact that negative performance could reshape the professional subjectivities of medical doctors, pushing them to treat their medical duties overwhelmingly in function to the monetary consequences derived by them and runs the risk of causing a potential threat to the public health as a result of the hierarchization medical duties imposed by the performance criteria prioritizing some medical practices over the others.

At that point, some of the participants pointed to another fact that I have not encountered during my pre-research before the fieldwork. I have learned from them

that the State is planning to launch a positive performance scheme for the family physicians, too, giving them the opportunity to generate additional income to their salaries for the medical practices that are not covered by the negative performance scheme. This may be considered a possible step to prevent the neglect of other medical requirements lying outside the scope of negative performance. However, the combination of a positive and negative performance scheme for the medical duties of family physicians is likely to result in the acceleration of the already economized nature of their professional subjectivity even further.

Another widely shared disturbance caused by the current negative performance scheme is the increasing quantification of the medical performance of family physicians. *“I am much more than those numbers indicate, but it is completely overlooked by the current administration at the end of the day,"* says Veli, complaining about the reductive nature of the current performance criteria. In a similar narrative, Melda states: *"I see my profession as a sort of craft. What creates the difference between a good and insufficient medical doctor is generally determined by the little details ignored by this model. All that counts is a numeric data reflecting the results for some medical practices, and I think that's not fair, at all!"* in a rather disillusioned tone visible in her speech.

The criticism based upon the reductive nature of the negative performance scheme does not end here for the family physicians as they drew my attention to another aspect involving critically framing the method of the calculation where those negative performance criteria are reviewed. The cumulative number of completed medical procedures subjected to the performance evaluation is translated into a respective percentile in the current system. However, this percentile calculation engenders an inherent risk for the unequal treatment of family physicians by the State. İlkay explains this the following way:

> *"If I have ten children to be vaccinated, my performance rate is measured as 90 percent when I miss out on one patient. On the other hand, if this number is 100 for another physician, let's say, missing out on a vaccination*

translates into a 99 percent completion rate. This much of a difference may seem absurd, but the demographics of each neighborhood are very different, and this results in a serious inequality in general."

The final point that I would like to address concerning the negative performance scheme is based upon the narrative of an exceptional case among other participants in the study. Mustafa is a family physician working in Bağcılar district in Istanbul as a dual citizen with Turkish and Arabic origins. He works mainly with an immigrant population as Arabic is his vernacular language. During the interviews, he was maybe the one who complained the most about the current performance evaluation scheme, and delving into the particular reasons for this discomfort may give us a glimpse about the enabling precondition, rendering the actualization of such a system possible in the first place and the problems triggered by the lack of it.

Out of twenty-one participants that have been interviewed, three but all of them mentioned that they suffered a loss of income due to not having met the performance criteria at some point in their careers. However, none of them were as severely affected as Mustafa did. He stated that nearly every month, his income is affected by a certain amount of performance cut, more or less. Only when he was asked why his situation negatively deviated from other participants, the specific difficulties of working with an immigrant population starts to surface.

Mustafa is a highly-regarded family physician by the immigrant community in Istanbul because they do not need a mediated communication by a translator. However, the qualities of that population are what renders him also highly vulnerable to the requirements dictated by the current performance evaluation scheme. First of all, it should be notified that they are not a stable population as their movement is strictly conditioned to an ever-present possibility of fleeing into mainly European countries as refugees rendering them extremely hard to reach. A second reason for that is rooted in their dire living conditions forcing them to move wherever they can find a job, making them harder to keep track of.

When Mustafa fails to find them in their declared addresses, a second wave of hardship emerges for Mustafa as he needs to prove that those people no longer live there. He emphasized that he cannot find anyone in general, be it their neighbors or the neighborhood mukhtar, to make them sign the necessary documentation proving that those immigrants do not reside in their apartments both out of the high level of xenophobia preventing their neighbors or any other person in charge to sign such a document and the sheer difficulty of finding someone who knows them in their neighborhood mainly rooted in the closed lifestyle of the immigrant population.

The humanitarian and public health concerns arising from their vulnerable positions are left aside, I would like to draw attention to a different point that can be deduced from his narrative and can be reviewed within the scope of neoliberal governmentality. At the beginning of the section, it is thoroughly discussed how the introduction of negative performance allowed the State to delegate some of its disciplinary authority to the family physicians in a way distancing itself from their citizens. Though, Mustafa's narrative detailing the hardships of working with a predominantly immigrant population in terms of performance evaluation reveals the existence of an already stable population whose movement is highly trackable or at least predictable and whose behavior and actions stay inside the legal framework predetermined by the jurisdiction of a country as a prerequisite of introducing such measures for the family physicians. The non-fitting character of his population to neither of those requirements makes Mustafa extremely vulnerable to a respective loss of income nearly every month.

Consequently, his experience of working with an immigrant population shows that the full operationalization of neoliberal governmentality's principles and their optimal implementation requires the fulfillment of some pre-defined qualifications most think of to be given in the current system of nation-states that are easy to miss out unless the existence of such a population stays out of the picture. In that respect, Mustafa's narrative is not a mere example pointing to the difficulties of satisfying the performance requirements while working with such a population but also hints at the very qualities rendering the formation of such an order possible in the first place.

3.4. Leave of Absence as a Co-Responsibilizing Mechanism: *"If you'd like to get paid during your leave of absence, you should get along well with at least one of your colleagues!"*

When the subjective effects of neoliberalization in the primary health care providers are under scrutiny, there is another crucial mechanism to be investigated for developing a more insightful approach to the everyday existence of family physicians in their workplace. The transformation of the means of taking a leave of absence for a family physician as exercising a well-rooted labor right under the current FHC regime should be considered in that respect, unleashing an unavoidable potential to reveal an additional mechanism for forming a neoliberal subjectivity for the family physicians, in general.

In the old primary health care provision regime of Turkey, where the CHCs provide the medical services all around the country, taking a leave of absence was identified as a predetermined labor right, in a similar vein with other civil servants as the medical doctors were able to take a full thirty days of paid annual leave without any restrictions. However, the enjoyment of this given labor right is subjected to a dramatic shift when the FHC model is introduced. The right to a thirty-day annual leave remained intact under the labor regime dictated by the FHC regime. However, it is required today that a family physician should give procuration to one of their colleagues in the FHC and should delegate the care of their patients to them in the meanwhile. The existence of an agreement with their co-workers at the side of a family physician secures the use of leave of absence in the form of a paid annual leave. However, if one cannot succeed in agreeing with one of the co-workers for replacing her/his responsibilities during that timeframe, the MoH assigns a provisional personnel as secondment for the time being or temporarily appoints one of the family physicians in the same FHC to replace the absentee family physician. In that case, a certain amount of money corresponding to the lost labor time is cut from a family physician's salary.

This arrangement is rigidly imposed by the State where emergencies such as a sudden illness, loss of a close relative, or even giving birth to a baby are not exempt from that liability. This rigidity translates into the manifestation of great disturbance on the side of many participants during the interviews. Celil, in a visibly frustrated vocal tone visible in his voice, narrated that he had to take unpaid annual leave for the worsening health condition and the subsequent death of her terminal-cancer patient mother as he was not able to find a replacement in the meanwhile. In another example, Tuğçe, only half in jest, stated that she could give birth to only one child as it was not possible for a female family physician to take a paid annual leave to provide for the needs of a newborn baby and overcome the difficulties of the postpartum period. Even though she framed her narrative in an ironic tone, it is telling that it depicts the strict nature concerning the use of paid annual leave by the family physicians.

Another aspect that should be addressed in this section is how the structuring of leave of absence is tied to the blurring of worktime and workspace tackled during the preceding chapter. Most of the participants complained that even though they manage to find a replacement in their positions during their leave of absence, they do not feel rested or relieved in that period as they constantly think about the state of affairs in the workplace. Tuğçe, in an illuminating example in that respect, states: *"When you're on vacation, you are constantly in touch with your colleague to check if everything runs smoothly or not. I can easily recollect many memories where I was making phone calls with my secondment to tell him what he should do for a particular problem of a patient when I was tanning on the beach"*. This results in the fact that one's leave of absence does not serve as a period where one can find a chance to forget about the hardships of the medical profession and regenerate oneself.

The obligation to find a replacement for fulfilling one's medical responsibilities during her/his leave of absence is ensured by a bilateral agreement between the colleagues co-responsibilizing each of them to fulfill their medical duties in the absence of the other. The participants of the study state that the scheduling of annual leave is arranged in a successive fashion where one starts using her/his free time only after the completion of another colleague's leave; resulting in a situation where one

should work significantly more right before or after taking a leave of absence. This situation is aptly Framed by Halide when she claims:

> *"For me, using my right to annual leave never ends up in a place where I feel refreshed and ready to get back to work. Because I know that when I am back, I will make a nearly double shift as my colleague will use her right after me, or vice versa. In any case, your annual leave is not an opportunity where you can rest your mind and body, but a great source of stress that you know will cause you to work significantly more at some point".*

Her narrative makes strikingly visible that the arrangement concerning the use of leave as such ends up in a situation for family physicians where a timeframe defined as extra-work may unexpectedly become one's professional existence and result in the dissemination of work through other areas of subjective reality as one should concern about her/his job even though one is on the annual leave or work significantly higher not to suffer a considerable loss of income based upon not reaching an agreement with one of the colleagues to compensate for the medical duties she or he cannot provide in the meanwhile.

One should further look into how the complexities of this labor arrangement are addressed and overcome for the family physicians as the current situation obligates them to come up with a clear plan to protect them from the further consequences of not meeting the required criteria for the use of one's annual leave. As stated earlier, the co-responsibilization of the colleagues in using their annual leave incentivize them to be on cordial terms with their colleagues to a great extent. The narratives of an overwhelming majority of the participants prove this tendency as they frame the necessity to get along well with their colleagues along similar lines. *"If you don't want to lose a significant portion of your income just because you take an annual leave, you should be on friendly terms with at least one or two of your colleagues, knowing that a good relationship is key here,"* says Veli in a summarizing fashion reflecting other participants' point of view, as well. He also hints at the economically motivated nature of having good relations with co-workers from the perspective of family physicians where the use of an essential labor right such as taking an annual leave can contribute

to the formation of a calculating self to the point that even the human inter-relations could be evaluated for their contribution to one's economic well-being.

One of the extreme moments where this tendency is underscored quite strikingly can be found in Ilkay's statement detailing that how this calculative state of mind operates when one has to agree with other colleagues to delegate their medical duties in their absence. *"If the respective registered populations of two family physicians are not close to one another when they agree on replacing each other, there is a serious inequality occurring as the family physician with a fewer population should undertake more responsibility*," he says, instantiating his narrative with a hypothetical example. *"Let's assume I will take a week off work and agree with a colleague as my replacement in the meanwhile. Let's say I have 50 patients incoming per week on average terms, and he has one hundred, on the other hand. In that case, his workload is increased by 50% during that time instead of a 200% increase in my workload when I will replace him as a consequence of our bilateral agreement. For avoiding that sort of inequality, I always tried to come to terms with colleagues that have the closest population with me and be on good terms with her or him as a consequence in a way not causing a serious disadvantage for both party."*

Even though, Ilkay constructed his argument around an ethical principle here, his narrative on managing his workplace relations in a way conforming to the economic aspect of the labor arrangements is quite telling. During the interview, he was aware that the extra time he would spend undertaking his colleague's medical responsibilities in his absence wouldn't pay him off any additional amount. Still, it would prevent him from losing a considerable portion of his income unless he can find a secondment to his place. This means that his search for a colleague who has more or less a corresponding population can be interpreted as an effort to minimize the extra responsibilities arising from replacing his colleague's medical duties as a consequence of the bilateral agreement between them.

Ilkay constitutes a solitary example in framing his workplace relations in a radically economized manner, calculating the costs of developing cordial relations

with his colleagues in terms of the extra amount of effort that would be spent in covering a loss of income rooted in not fulfilling the current requirements in place for using one's right of annual leave. However, the existence of another mechanism invented by family physicians as a solution addressing this problem serves as a validating proof of his narrative. Today, even though the use of leave of absence in a problem-free manner by the family physicians is mainly realized within respective independent bilateral agreements between colleagues; it is also possible to encounter FHCs where this responsibility is delegated equally to all the medical doctors working there evenly.

It should be stated that this is not a solution officially recognized by the State, and a colleague should undertake, at least on paper, the fulfillment of those responsibilities, anyways. However, in a place where it is agreed upon for an equal distribution of the medical duties of an absentee family physician, this individual liability is seemingly on paper and the responsibility is dealt with collectively. Nevertheless, it should be stated that it does not point to a novel invention on the side of family physicians. This practice is primarily inherited by the former CHC model, where the absence of a general practitioner is hurdled with the allocation of that person's medical responsibility to other colleagues equally. This serves as a clue showing that even though the introduction of the FHC model involved a radical restructuring of the former model, some traces of it can still be observed in various places, especially when countering the effects of the FHC model requires coming up with alternative solutions and these are primarily found in the former regime of CHC by family physicians.

However, with an equal distribution of one's medical duties, comes a greater co-responsibilization for each family physician when one wants to take annual leave. The participants working in such places emphasized that everyone should be consenting without any exception to that solution work appropriately for each one of them, and maintaining cordial relationships with colleagues become even more of a necessity in that case. An overwhelming majority of the participants working in an environment where the medical responsibilities of a family physician taking a leave of absence are

distributed equally expressed a favorable opinion concerning this solution. Still, one specific example negatively correlates with the generally positive outlook regarding this practice. Halide is working in such an environment, and she has some reservations manifesting themselves the following way:

> *"Most of my friends are pretty satisfied with this as we don't have to face a heavy burden when we decide to take a leave. Though, I feel I am not on the same page with them. I would like this to be handled otherwise. When I am on leave, for example, I would have preferred a single colleague to take care of my patients as I could have informed her about the specificities of my population. When that's equally distributed among all the colleagues, I can't notify each of them concerning how they should treat such and such patient. Agreeing with a friend would give me that option without a doubt. That's why I find most of my patients to be troubled when I just get back from the vacation. That wouldn't be the case if I could choose to whom I would delegate my responsibilities during my leave."*

Her criticism concerning the collective undertaking of a family physicians' medical responsibilities when she/he decided to take a leave out of work points to her willingness to protect the personal autonomy over a more collective undertaking of medical and spatial responsibilities in the FHC. This brings us to a place where varying effects of neoliberal subjectification are reflected on labor peace. It manifests itself clearly within the embedded tension along these lines. It also disrupts a good set-up medical tradition where collective effort is generally put ahead of individualizing tendencies.

3.5. The Disruption of the Labor Peace and the Medical Tradition: *"Younger colleagues are not asking for my advice anymore. It wasn't like that back then in my youth!"*

The neoliberal subjectification of family physicians is discussed under various headings so far, emphasizing its further implications for medical doctors. However,

two significant trends that come to the forefront in that respect can be singled out. One of them is an increasingly economized manifestation of their selves, and the other is their desire for a more individualized professional existence, granting them a more expansive. However, these two major priorities are primarily juxtaposed in a somewhat antagonistic dynamic. It should be stated that even though these trends are framed in an antagonistic relationship by the participants, it should be highlighted that both economization of the self and the other individualizing tendencies can be count among the main components of what constitutes a neoliberal subjectivity. In that respect, the main question to be asked in addressing this discrepancy is why seemingly consistent qualities of a neoliberal subjectivity are juxtaposed in an antagonistic framing by the participants? The answer to that necessitates bringing up the current composition of the FHCs into our focus once again as it holds a key position in understanding the nature of the existing conflict for the family physicians.

When the FHC model was introduced to the Turkish healthcare system in 2005, it stipulated a radical break from the former model concerning the working conditions of the family physicians and altered the meaning of being a medical doctor working in the primary health care dramatically. However, it remodeled its spatial governance regime using the infrastructure provided by the former of CHCs, where multiple medical doctors worked under the same roof. The resulting FHC model, while replacing its predecessor, remained this multiple unit model mostly intact as single unit FHCs constitute still a marginal percentage of the current stock of FHCs throughout the country. In the current spatial governance of FHCs, even though the monthly allowances are distributed individually, the joint responsibilization of the spatial responsibilities, monthly expenses, and the employment costs was much more favorable than the individual efforts as this provided the conditions of scale economics for them and enabled a financially more efficient running of the place, allowing a significant increase in their salaries, too.

However, the rise in economic efficiency was obtained at the expense of a limitation of their autonomy as independent agents. In that respect, it can be said that the antagonistic positioning of common responsibilizing for the family physicians and

a growing desire to act as autonomous agents that are independent in their acts and decisions is primarily rooted in the current spatial organization of the FHCs based upon the remnants of the preceding CHC model. As a result, there appears a conflict between the wills of family physicians prioritizing shared handling of the responsibilities of the FHC and those who opt for a more broadly defined individual field of action in their decisions.

This divergence between the priorities of family physicians working in the FHC can be interpreted along the lines of a generational divide manifesting itself quite starkly during the interviews. The experienced family physicians who also lived through the CHC era were much more in favor of a co-responsibilizing stance, whereas younger medical doctors were prone to frame their position as family physicians significantly individualistic terms. However, it should be emphasized that this diverging attitude between younger and more experienced medical doctors is only observable regarding the economic liabilities of a family physician's job definition. A further individualizing tendency is observable in nearly all participants concerning their medical responsibilities, a few notable exceptions set aside. However, catching the full-scope of that generational divide and sparing it from being defined as a self-proclaimed categorization; one should look at how the participants have formulated it mainly in the contours of a transforming medical tradition where a more individualizing tendency among family physicians take over a collective approach.

The transforming nature of medical tradition in primary healthcare provision can be developed under two differing categories. The first one comprises tackling an alteration in the administrative and managerial side of the medical profession within the FHC model. In contrast, the second focuses on an isolating tendency between family physicians, limiting the transfer of medical information and experience. Both of these two major lines will be developed with reference to the participants' narratives throughout the rest of this section.

A significant portion of the experienced family physicians involved in the study complained about the harshness of dealing with the heavy burden dictated by the

managerial responsibilities co-owned by the medical doctors in the current system. *“As you get older, you don’t want to deal with all the administrative drudgeries of the profession and solely focus on your medical duties. However, this equal distribution of managerial responsibilities requires you to deal with them. Our young colleagues are very inconsiderate about that as they don’t offer to take this burden out of our shoulders,"* says Nermin, to emphasize the visible discontent towards running the place. She also frames her argument in a comparative dialectic where she contrasted the former model of CHC to the replacing FHC scheme when she said: *“Back then, experienced doctors were in a much more respected position as they were consulted in the moments when experience makes a difference, but also they were much more comfortable regarding their managerial duties as younger physicians mostly handled these. They had sort of this ombudsman status whose views and advice have been respected in critical moments but enjoying a comfortable position as well”.*

Her discontent towards the lack of a well-preserved status in the former model echoes the other narratives of more experienced physicians in the sample. However, paying attention to how younger family physicians frame this generational divide is crucial to not miss out on the broad picture. In that respect, the narrative developed by Aynur is symbolic of the point of view expressed by younger participants when she said: *"The more experienced colleagues want me to both bear more responsibilities and have less say in the decision-making process at the same time. When I disagree with them, it mostly results in a fight as they want to protect their former privileges. I object to that because I think I work as hard as anyone in this place. I am also given an equal budget in handling the responsibilities, and I think that should give me an equal opportunity when a crucial decision is due."*

Aynur's dissenting argument that can also be framed as an answer to Nermin indicates a tendency where equal economic responsibilization is translated to a demand for equal treatment on the side of younger physicians. However, it can be deduced without taking that the current spatial governance of the FHC model triggered a significant transformation concerning the managerial duties towards the FHC where the demand for equality on the side of younger physicians can be expressed more

tenaciously regarding the equal co-responsibilization and participation to the financial management of the place for all family physicians. In that respect, it can be argued that the economization of their subjective existence constitutes the main ground for the equal treatment demand for younger family physicians. In contrast, more experienced medical doctors express their claim on serving as an ombudsman concerning the running of the place in the ground of a medical authority rooted in the traditional structuring of the medical profession.

Another potential conflict between experienced and younger family physicians is the limitation of the transfer of medical knowledge and expertise between them grounded on the isolated positions of family physicians. In another example derived by Nermin's narrative, she claimed that sharing medical expertise between colleagues decreased significantly after the introduction of the FHC model where a more individualized approach towards the fulfillment of medical responsibilities replaced a more collective approach to the. She claims that the harmful character of this tendency is especially evident in the treatment of complex cases where it can be challenging to make an accurate diagnosis, and a second opinion from a more experienced colleague can be of great benefit for family physicians. Another participant also identified this aspect as one of the main drawbacks of the FHC model. *"A colleague was tossing an anecdote when we were having lunch together the other day. She stated that she recently had a patient with a rare medical condition called strawberry tongue among doctors. If I were in her place, I would ask the patient's permission and call my other friends to share this rare prognosis with them. But we don't see that these days as most family physicians keep their patients to themselves,"* says Halide, pointing to another dimension of this limited dialogue between family physicians; enclosing their subjective position more and more to the exchanges with their peers and strictly focusing on the relationship with their registered patients; resulting in a restricted environment where the medical learning is significantly curbed.

3.6. Conclusion

The main focus of the chapter was the contractualization of the family physicians' labor and its subjective and inter-relational consequences within the FHC. *"The main innovation of neoliberal technology precisely consists in directly connecting the way a man 'is governed from without' to the way 'he governs himself from within'"* says Dardot and Laval (2014, p.264) fittingly to the way this contract came to be effectuated. It was a major step forward for altering family physicians' working conditions in a way leading to a neoliberal subjectivity where an internal governing dynamic has been constituted for them. However the *modus operandi* of the contractualization needs to be elaborated more in depth here concerning how the contract may provide the constitutive framework of a neoliberal subjectivity. *"More than ever, the contract became the yardstick of all human relations"* says Dardot and Laval and they add: *"as a result, the individual increasingly experienced in his relation to others his full, complete freed*om of voluntary engagement, perceiving 'society' as a set of relations of association" (Dardot and Laval, p. 257).

This emphasis on the freedom of subjects entering into contracts can nevertheless be tricky under given circumstances. As there is no other chance but to sign the contract for medical doctors who would like to work in the primary healthcare service, the contract appears as a binding document where family physicians hold no negotiating power. Still, the perception that the contract is a piece of document voluntarily signed by them holds strong as can be observed in their narratives strengthening the image of a free association between the State and the family physicians. The other implications of the contract have yet to be developed, though. Dardot and Laval specify that "*underlying the contract is something other than subjective freedom. There is an organization of normalizing processes and disciplinary techniques that constitute what might be called an apparatus of efficiency*" (2014, p. 257). The main novelty of the contract can be reevaluated better in light of that explanation as it provides an adequate framing for participants' narrative throughout the interviews.

The contractualized nature of work implies an intensification of family physicians' efforts during work for improving their income contributing the above mentioned *"apparatus of efficiency"*. Working on a flexible payment regime, family physicians have to increase their registered population as much as they could to yield a more substantial income at the end of the month enabling the State to achieve a higher efficiency concerning the patient per doctor ratio. The imperative of an enhanced efficiency does not stop there for the family physicians, too. The introduction of evaluative mechanisms such as performance measures and penalty points by the FHC model *"are supposed to make it possible to objectify the individual's conformity to the behavioural norm expected of him, to evaluate his subjective involvement by means of grids and other recording instruments on the manager's 'control panel', on pain of penalization in his job, wage, and career prospects"* (Dardot and Laval, p. 263). The accuracy of that argument is also supported by the participants' narratives manifesting itself in increasing vaccination rates, the utmost attention on not missing out the required task and a resulting a self-disciplining approach.

Although, the performance measures are also harshly criticized by an overwhelming majority of the participants concerning the deceptive potential of evaluative techniques to provide a healthy assessment of a family physician's qualities, the quantification of performance has another implication to be elaborated, in that regard. *"The main thing, however, is not the accuracy of the measurement, but the kind of power that is exercised 'in depth' over the subject invited to 'give himself unreservedly', to 'surpass himself' for the enterprise', to 'motivate himself' ever more the better satisfy the client- that is, commanded by the kind of contract kinking him to the enterprise, and by the mode of evaluation applied to him, to prove his personal commitment in work"* says Dardot and Laval (2014, p. 263) in resonance with the discursive framework employed by the participants in their narratives.

Giving oneself unreservedly to the work as formulated by Dardot and Laval can be linked with the intensification of work blurring the limit between one's personal life and work time and space to a greater extent in the FHC model. In that respect, it would not be wrong to argue that *"the notion of 'personal enterprise' assumes an*

integration of personal and professional life (...), and a change in relations to time which will no longer be determined by the wage contract but by projects to be carried out" (Dardot and Laval, 2014, p. 267). Extra-medical responsibilities included in the work definition of medical doctors in the FHC model are mostly dealt with in non-working hours as emphasized by the participants fits into that determination precisely. Even though family physicians are mostly complaintive for that aspect of their job, they also adapted their novel conditions of work quite well by adopting the use of instant messaging apps such as WhatsApp to deal with that extra workload.

One of the far reaching consequences of the contractualization of family physicians' labor can be observed in the way it transforms the workplace relations between colleagues. Incentivized for being more efficient subjects in every aspect of their professional existence, family physicians are acting in a co-responsibilizing framework with their co-workers in tackling the newly attributed requirements of their work such as employment obligations or changing scheme for using one's leave of absence in a way not resulting in an income loss for their salaries. This joint sharing of these responsibilities should be considered within the neoliberal framework where *"relationships are two or more neoliberal collectives creating a partnership that distributes responsibility and risk so that each can maintain their own autonomy as market actors"* (Gershon, 2011, p. 540).

However, this co-responsibilizing tendency for family physicians are mostly translated into an agonistic expression where a significant loss of autonomy has been problematized by the participants. Even though, suppressing their risk through a distributive tendency concerning their responsibilities enhance their capacity to act on their own will jointly in the face of threatening sanctions of the State compensating their possible loss of income rooted in their capacity to act together, it nevertheless constitutes a considerable impediment to their individual autonomy as strongly mentioned during the interviews especially by the younger family physicians.

This negative framing of the necessity of joint action regarding their managerial responsibilities are mostly marked by a conflict of generations between older and

younger family physicians as the latter group favored a more independent approach to their work while the older physicians complained about the disruption of the medical tradition rooted on younger colleagues' demand for more autonomy in their actions. This conflict is mostly shaped within a comparative framework where the old spatial regime of CHC model has been contrasted to the current FHC scheme especially by the older family physicians as this co-responsibilizing tendency is mostly shaped by the remnant dynamics of the former primary health care model allowing them to benefit from the advantages of a multi-unit FHC structure.

In that regard, the arguments of actually existing neoliberalism literature should be renewed one more time here as neoliberal policies are never operating in a vacuum but mostly embedded in the former institutional structures and practices. Developing the current FHC model through the multi-unit CHC structure, instead of opting for a radical break and identifying the FHC as a single-unit independent primary healthcare provider resulted in the formation of strategical alliances on the side of family physicians, engendering both an enhanced financial efficiency providing a higher income for the family physicians but at the same time a spatial governance where their autonomies are curbed severely in this co-responsibilizing regime.

-4-
NEOLIBERAL SUBJECTIFICATION THROUGH DOCTOR-PATIENT RELATIONS

4.1. Doctor-Patient Relations Redefined: *"After a certain point, you develop a sense of family with your patients. I have cried when I found out one of my former patients died."*

The varying aspects of the spatial responsibilization of family physicians and the subjective transformation based upon their novel labor arrangements have been examined so far within the scope of our study; and how these subjective alterations expressed themselves in the narratives of the participants and how they could be interpreted in the context of neoliberal subjectification along the lines of Foucauldian tradition of neoliberal governmentality. However, a study focusing on the everyday experiences of family physicians is never complete without a thorough assessment of their relations with the patients as the main target of their medical authority.

Concentrating on how their relationships have been reframed under the novel spatial arrangements dictated by the FHC model bestows a more insightful look into the actual field through the narratives of the participants whose subjectivities have been remodeled not only in line with their managerial and spatial duties but also through a radical reassessment in their treatment with their patients. In the end, all the other modulations realized concerning the labor arrangements and the exponential growth of their spatial is only meaningful when those effects are put under scrutiny in an inter-related manner with the way family physicians treat patients.

Nevertheless, this effort requires above all a deeper apprehension concerning how the doctor-patient relationship has been reevaluated under the FHC governance and how the introduction of some measures in that context radically shifted the dynamics of this relationship and the very definition of being a medical doctor in itself. To that end, two principle mechanisms redefining this dynamic introduced by the

implementation of the FHC system by the State will be elaborated during that section. These are the identification of a specific registered population as a *sine qua non*-constitutive moment for serving as a family physician in an FHC and the right to choose a doctor for a patient as the primary mechanism regulating the scope of each family physician's respective population and the demographic movements within that population.

The obligation to work with a registered population is among one of the most crucial novelties brought by the FHC model as it completely remodeled the working principles of family physicians in numerous ways. It was a radical break from the traditional model where medical doctors took care of every patient visiting them randomly within a polyclinic order; covering a particular geographical area's primary health care needs. This was marked by the former model of CHC, where a public health approach was privileged over an individualistically oriented primary health care provision.

However, under the current spatial regime dictated by the FHC framework, family physicians have been responsibilized for taking care of a strictly registered population under their name. In that respect, this registered population is the main contributing factor for determining their salaries. To that end, it can be argued that this population is structured on both vertical and horizontal axes. The vertical axis, here, simply implies the quantification of that population. In contrast, the horizontal plane points to a differentiation among that population based on the particular qualities of the individuals constituting it. This structure forces them to take notice of both the cumulative number of their population and fulfill other specific criteria regarding that population that will be specified later on.

Each medical doctor serving as a medical doctor in that system should have a minimum population of 1,000 and this number may surge up to 4,000 as specified by the current FHC legislation. On rare occasions, this number may exceed the maximum threshold of 4,000, especially in larger metropoles like Istanbul, where there is still a severe shortage of FHCs to meet the demands of the large population. Family

physicians are paid a respective amount for each patient registered under their name, so that maximizing one's population becomes a top priority. Even though the minimum threshold for securing one's labor contract for is determined as 1,000; the large gap between 1,000 and 4,000 is translated into a substantial difference in the respective salaries of two family physicians channeling them to register as many individuals as possible to achieve a higher income.

The cumulative number registered by a family physician is not the only benchmark in determining one's salary in that system. The population registered to each family physician is classified under five respective categorizations appointing each one of those categories a different coefficient when calculating a family physician's salary is due. A patient aged between 6-65 is accepted as a standard patient in that model, and a coefficient of 0,79 is appointed to her/him. A registered patient who is a pregnant woman is assigned a coefficient of 3; a prison inmate 2,25; a child aged between 0-6 and an older adult aged 65 and more are appointed a 1,6. The amount and the percentage of those respective categories vary for each family physician, causing them to have differing incomes even though they have the same number of patients registered. It also translates into a fluctuation for family physician's salaries as those numbers are subject to the continuous change in function to the changing demographics of a registered population.

The direct positive correlation between one's respective registered population and the earned income engenders consequences affecting the subjective conditions of family physicians beyond their economic well-being. One of the primary consequences that can be drawn from that dynamic is a deeply-felt concern encountered in case of a sudden loss in a family physician's respective population. In a fitting example, Canan illustrates this anxiety rather expressively when she says: "*There was a new family health unit opening in our FHC, and we gave up about ten percent of our patients to our new friend. But, it meant a ten percent loss of my monthly income, and yearly, the amount I've lost was more than a month's salary for me. I know it was ethically the right thing to do, but now I have 11 month's salary to cover a year's expenses,".*

Her narrative is not a particular example but part of a discourse that can be encountered in many participant's statements as the economization of family physicians' professional subjectivity through a mechanism of the registered population does not end there. Another tendencies accompany the anxiety for losing a significant portion of a family physician's respective population based on the consequent loss of income involving a more pro-active approach regarding the composition of the registered population. *"When the circumstances allow you to organize your population in a way that suits you to procure a higher income, you may bolster your chances by taking action,"* says Ilkay underscoring the imminent tendency within family physicians to interpret one's population in terms of a customer portfolio where an added value can be extracted by juggling with the composition of the population. This common perception already present in an overwhelming majority of the participants can be summarized as turning one's population into an asset in compliance with the market mentality.

This propensity towards structuring a family physician's registered population more as an asset and less as a group of people whose medical needs should be addressed by a medical doctor within the ethical framework of the profession can be found in various interviews on a discursive level. However, this recently developed disposition is expressed rather self-evidently and accompanied with anecdotal evidence in some accounts. Canan's narrative detailing her assignment to a new position in another FHC and her dialogue with her predecessor before taking over his role provides nearly a caricaturized example in that respect. *"We made a symbolic handover ceremony before I started. In that meeting, he bragged at great length about the qualities of his population saying, 'You have inherited a very balanced, problem-free portfolio of 3800 patients! What more could you ask for?'"* she said in a troubled manner questioning the attitude of her colleague. Nevertheless, it is still a significant example for showing the potency of this approach in the everyday experiences of a family physician.

However, it should not lead one to think that family physicians hold an exclusive authority concerning the composition of their population despite the existence of such examples. It can be argued, on the contrary, that this novel arrangement cannot be tackled out without taking into consideration how this regulation is structured in a way yielding more authority to the patient. The scope of a family physicians' respective population in the FHC model is held liable to the patient's right to choose her/his family physician to a great extent. Unlike the former primary health care model, where patients are taken care of by a random medical doctor working in the CHC, the current model grant the patients the right to choose their family physician, and have the leverage concerning the continuation of this relationship. If an unsatisfaction with the medical services provided by a family physician occurs, a patient can switch to another doctor immediately without her/his decision being questioned in this model.

Even though the doctor-patient dynamic is a bilateral relation necessitating an equal treatment of both parties' narratives to reach a complete picture, only family physicians' arguments could be discussed here as the scope of this study does not include patient interviews. When we try to grasp the complexities of this dynamic through family physicians narratives, it is possible to delineate two opposing tendencies standing out relatively among the others; and the primary analytical axis tackling the evolution of patient-doctor relations within the FHC model and the way(s) it affects the formation of a neoliberal subjectivity on the side of family physicians will be grounded on those tendencies during the rest of this section.

The first one of those tendencies comprises realizing an idealized version of family physician identity for the participants reflected in their relationships with their patients despite the increasing power of patients in the FHC scheme marked by the transformations detailed above. However, the appreciation of this idealized family physician status, first of all, requires having a deeper understanding of what it means for medical doctors to be a family physician and how they see it differently from the rest of their former position or the rest of the medical doctors in the current healthcare system in Turkey.

For an overwhelming majority of the participants, the concept of the family physician is structured in a relatively privileged position where its defining aspect lies in the long-lasting and intimate character of their relationship with their patients. Even though there are slight alterations in their population based upon the respective demographic movements or patients' decision to change their family physician, as long as a medical doctor works in the same FHC, her/his population stays intact for many years allowing them to develop closer relationships with their patients. *"With the passing of the time comes a strong sense of reciprocal trust for each other and cordial relations with your patients,"* says Selim echoing the standpoint of other participants. Many other participants also stated that the level of satisfaction from one's relationship with their patients is directly proportionate to the time spent with them and a high level of acquaintance with each other over time. As might be expected, the problematic aspects of the doctor-patient dynamic are put on the right track on the ground of mutual understanding and developing the skills of working things out together by acknowledging each other's traits and tolerating each other when necessary, in that respect.

This more or less stabilized population also allows them to observe the life course of their patients and the evolution of the status of their health more closely, locating them within the borders of a consulting position, assisting their patients who are willing to improve their health. In the specific case of family physicians, their help can be retained as long as patients recognize the authority of their physician and remain committed to the service and consulting provided by them. A ubiquitous metaphor employed by the participants to frame their long-lasting and intimate relations with a respective portion of their population is *"like one of the family*."

This frequently referred expression is used both figuratively and literally by family physicians as their long-lasting relationships exceed the limits of an individual doctor-patient dynamic as the members of a family often register under the name of the same family physician, and this allows them to develop exclusive ties with each one of them. *"We see babies we took care of growing up and starting the school; we hear one of our patients dying and attend their funerals; we see our patients marrying,*

divorcing, having hard times, good times… We are a direct witness to their lives, and in the end, you inevitably feel like one of the family. I think this feeling is mutual for our patients, as well," says Veli, giving a summary and articulating the standpoint of other participants in the same vein with him. Some even state that they treat some of their registered patients as friends beyond their formal doctor-patient relations, materialized by examples such as attending their special occasions, weddings and so on.

This can bring into mind that this enduring relationship between patient and the doctor, sometimes crossing the boundaries of a traditionally defined medical ethics and blurring the limits between the family physician and the patient, may damage the primary aim of this relationship that is helping out an individual's health problems. However, it should be strongly emphasized that the narratives of family physicians always point out to an ever-present medical gaze, and the consequent satisfaction derived by maintaining intimate relationships with their patients is mainly rooted in family physician's ability to guide their patients for improving their health. Having close connections with their patients is not an end in itself for the participants, but a means through building a solid relationship based upon mutual trust for each other enabling them to become more active agents. *"As family physicians, we are different than the rest of the medical doctors, I think,"* says Halide stressing the particular position they hold within the healthcare provider and adds: *"We are not here to address the immediate problems of our patients and operate them, for example. Our primary focus is to guide them to achieve a higher quality of life marked by healthier choices ensured by our sound and their predisposition to listen out those pieces of advice based on the mutual trust between us. Only then, having close relations with them is meaningful.*

Her narrative is quite explicit in enlightening the function of being on good terms with their population and the potential benefits of being *"like one of the family"* by family physicians. This close connection enables family physicians to have a better outlook on their general health, the evolution of their medical histories, genetic diseases running in the family, their living conditions, and even specific information

concerning their daily routines like eating and sleeping and so on. It is hard to acquire this extensive amount of knowledge acquired by a family physician within the limited timeframe of a regular doctor appointment by another physician. In a telling example illustrating that Tuğçe shares an anecdote concerning her contribution to the healing process of a patient the following way:

> *"I had a female patient suffering from severe back pain and diagnosed with spinal disc herniation and advised for an emergency operation by an orthopedist. She came asking my advice on whether she should accept the operation or not. I knew that this woman was suffering from OCD for years and obsessed with cleaning, causing her to tire her body extremely. That could be a potential reason for her insufferable back pain. I talked about it with her, relying on our close relationship with her, and advised her to see a psychiatrist and opt for physiotherapy initially before undergoing the operation. In the end, she both started a therapy process easing her OCD considerably, and physiotherapy also worked to render the operation currently redundant. When she visited me the last time, she thanked me for my intervention and hugged me cheerfully. However, you should know that this kind of a result is only possible within the family medicine model as a specialist can never know the same amount of information you do about a patient."*

The long-lasting and trust-based relations between family physicians and the patients are profitable also for those who are skeptical about the medical discourse and distanced themselves from their physicians initially. Some of the participants stated that they managed to convince some of their patients who were negatively biased towards vaccinating themselves or their children based on their moral beliefs over time. *"In the former system, I couldn't do it as the patient and I was not close enough to convince him that there is nothing wrong with the vaccination. If there is a success here, it cannot be explained by me being a good doctor but by the nature of our relationship spanning years and building up mutual trust between us,"* says Melda on that account and praises the family medicine model that respect.

Some other participants also underscored that the trust-based nature of their relationship with the patients also allows them to shape their patients' attitudes in a way conforming to the medical discourse, enabling them to help their patients more effectively. Halide, to point out her struggle with the patients, highlight how she helped their patients to frame their medical problems more articulately over time as follows:

> *"When I first came here, there were too many patients to be taken care of every day, and I realized that they weren't aware of what their problem was coming here or they couldn't articulate it properly. I took my time and explained to them how to express their medical problems, medical history, when to come here, and when to avoid it. Now, I have much fewer patients per day as my population is highly self-conscious about their health care conditions. When they come to see me, we have a much better communication allowing me to diagnose them more easily."*

Her narrative and other anecdotes shared above are reminiscent of other participants as well, and they can be multiplied easily. In another respect, though, this narrative of an idealized family physician image is also highly compatible with the principles of neoliberal governmentality. As its primary mandate can be formulated as *"governing from a distance,"* (Rose, 1999) the ideal role attributed by family physicians to themselves is formulated as improving the quality of life for their patients by providing them medical assistance as long as they are willing to cooperate with them. The respect earned through the trust-based relationship between them is the primary medium through which their consulting position operates. However, even when they try to help as much as possible, they leave the final decision to their patients and keep a minimum level of distance to avoid intruding further on their lives.

One crucial point to be emphasized concerning this ideal position defined in parallel with neoliberal governmentality principles is the lack of generalizability both for the participants and the family physicians in general. Even though most of the participants seem to be embracing this position, and their narrative also proves the existence of such a relationship with their patients, one should not overlook the fact

that this reflects only a limited picture of the doctor-patient dynamic within the family medicine model. Positive aspects left aside, the problematic side of their relations with their population was much more highlighted during the interviews, and this rosy picture can be interpreted as a consolation for them within an environment where the family physicians have blistered patients and the FHC model itself. In light of that information, the different ways participants problematize the relations with their patients connect to the neoliberal subjectification process.

However, before moving on how the problematics aspects of doctor-patient relations have been evaluated by the participants, it would be better to mention how this redefined relation, empowering the patients to a great extent and curbing their medical authority at the same time are reflected within peer-to-peer interactions. Aside from reshaping the ground where the doctor-patient dynamic has been structured through the introduction of novel measures such as granting a patient the right to choose her/his own family physician; the reconfiguration of this relationship has further implications to be analyzed to better understand how each family physician's respective position has been identified within the framework of a competitive discourse, helping to transform them into entrepreneurial subjects through their struggle to preserve and increase their population within a flexible wage dynamic.

4.2. Entrepreneurialization of Family Physicians and Surging Competition: *"You see fliers circulating on internet forums promising all kinds of services to the patients if they change their family physician."*

"The entrepreneurialization of the self" is a concept that can be encountered nearly in every account detailing the neoliberal subjectification process to a certain degree. If we can talk about a neoliberal subject in general, entrepreneurialization is the *modus operandi* where this subject operates. Investigating the traces of this mentality on the side of family physicians is crucial in that respect; not only because it may serve as a validation of what is being pursued in this study from the very beginning, but also such an investigation carries the potential to reveal other facets of a family physician's everyday subjectivity that could have been overlooked otherwise.

However, looking for some sort of evidence proving the existence of an entrepreneurial mindset can be tricky on its own. Nevertheless, some of the chief reasons explaining the task's difficulty can be singled out over the others. First of all, despite their special status within the Turkish healthcare system, granting them some rights such as the introduction of the employer status or managerial responsibilities; they are ultimately contracted employees whose field of action is strictly restricted to develop entrepreneurial qualities. The limited nature of their job definition based upon their labor contract; restricting their income to rise above a certain threshold and depriving them to act as independent agents serving in the private sector are also significant contributing factors for a thriving entrepreneurial character for the family physicians. Still, these defining aspects of being a family physician in the FHC model cannot be interpreted as a strict absence of entrepreneurial tendencies for family physicians at all.

Acknowledging this tendency and understanding how it is operationalized for family physicians requires considering how the FHC model throughout the country has been structured as a quasi-market. In the case of the FHC model, this structure has been set up by introducing a further spatial responsibilization for the family physicians granting them higher budgets in return for the fulfillment of determined criteria ensuring a better physical environment for the patients; and a guarantee for an elevated income in case they attain a higher registered population than their colleagues. Especially this second feature where the State incentivize a higher pay for a more significant population results in a competitive environment where registering an optimal number of patients for family physicians serve as the fertile ground for developing an entrepreneurial character.

Understanding this tendency more deeply requires detailing out how the competition has been defined in itself and how it gets to be working in the family physicians' everyday lives, in the first place. It is crucial to underline that the competition within the FHC has been chiefly denied by an overwhelming majority of the participants. In that respect, it should be noted that many of the participants stated that competition does not exist within the workplace as the family physicians are

exclusively held accountable for their patients. However, we have to underscore that the absence of competition within the workplace does not solely emanate from the fact that each family physician is responsibilized for taking care of their respective population. The co-responsibilization regarding handling the spatial responsibilities is a major contributing factor limiting workplace competition, as it can be observed in different narratives.

"We don't steal each other's patient within the workplace as we agreed on that. If one of us tried to do that, it would severely damage the labor peace in the FHC, and make life unbearable as it could trigger potential conflict between the colleagues. That's why we pay attention to not crossing each other's boundaries as colleagues," says Veli in explaining why competition within the workplace is limited as running the place smoothly takes precedence over having a more comprehensive portfolio of patients in keeping the labor peace intact. However, the absence of workplace competition does not translate into a total annihilation of the concept. One has to look elsewhere to understand better how the competition has been operationalized within the FHC scheme.

Doing that, we should look towards the targets set by the Ministry of Health concerning the aims of the family medicine model. The ministry foresees a maximum of 2,000 registered patients per family physician in 2023 (TAHUD, 2013). Even though no officially released data points to the current average, a report launched by the main political opposition party CHP (CHP, 2020) estimates this number as 3,405. This number could be higher in metropoles such as Istanbul, where a significant shortage of medical doctors have been addressed by several sources (Medimagazin, 2014; Türsen, 2018) and where most of the participants of this study are currently working. This gap between the targeted numbers and the current situation results in an aggressive campaign by the ministry trying to addressing the problem by introducing more and more virtual FHCs to the system each year to reach the set target. And this is where we should maintain our focus to understand how this growing number of virtual FHCs in Istanbul and elsewhere in Turkey translates into a furthering

competition between family physicians and the flourishing of entrepreneurial tendencies based on that mechanism.

As it was discussed in earlier chapters, the medical doctors who are appointed to positions in virtual FHCs start with zero population to their careers as family physicians, and they are expected to rise this number to at least 1,000 due a year; or they may face the unilateral cancellation of their contracts. Reaching that number may be considered as a reasonable target as most family physicians should work with an over-saturated population, sometimes even exceeding the maximum number of 4,000 patients in the current condition. However, this requires convincing 1,000 individuals, each of them one by one, to cut their ties with their current family physicians and registering them under their name.

Registering 1,000 patients within a year's mark is not enough in most cases, though, as earning a satisfying income requires having a much higher population under the current legislation regulating family physicians' salaries. As a family physician who underwent this rather painful process, when asked about the difficulties of registering such figures during that time, Aynur responded: *"We are talking about obtaining a population of 1,000. It doesn't stop there, though. The sufficient number required to have a comfortable life and maintaining your career as a family physician is between the range of 2,500-3,000 considering current economic circumstances in the country"*. Her narrative shows that having a higher registered population is a top priority for family physicians in virtual FHCs with zero population. Reaching that number may necessitate introducing a more aggressive strategy and an entrepreneurial mindset as they do not own the advantages of an already-acquired population experienced by other family physicians.

Even though I have not encountered such a participant during the interviews, the participants' narratives and the documents shared by them enabled me to cover this subject more thoroughly here. While talking about how these thresholds operate in the everyday lives of family physicians, Veli told me about medical doctors who are running some sort of marketing campaign for their newly-opened virtual FHCs to

attract more patients to their place. His testimony revolves around family physicians wandering around the neighborhood, knocking on the doors of their targeted population, and distributing fliers and other documents mentioning the advantages of switching their current family physician and asking them registering under their name.

I asked him whether he can share some examples supporting his arguments and enabling me to have a better outlook on those. He hesitated at first, as using this document on the study may harm parties preparing it. Though, he accepted my offer as I assured him that I wouldn't be using any kind of information revealing the identities of any party and sent me the images of those fliers as I can analyze them and involve in the study without mentioning any names whatsoever. In that respect, those images will not be shared with the reader. Still, they will be elaborated here as they provide striking to catch a glimpse of the development of an entrepreneurial subjectivity. Those two fliers, both used by medical doctors starting their careers as family physicians in virtual FHCs recently. The first one of those documents is a personal flier containing more or less a basic amount of information such as the address, a detailed sketch showing the exact whereabouts of the virtual FHC, and a couple of services that could be provided by the family physician such as medical reports, reports for prescribing necessary medicines for patients who have chronic diseases, etc. A telephone number is also provided for further questions. The easiness of switching one's family physician is further accentuated with a sentence stating that it is just enough to bring one's ID card to change your family physician.

In the other flier that serves the same purpose as the preceding example, it is possible to find traces of a more intense vocabulary of marketing rhetoric. It needs particular emphasis, for that matter. This document starts with a legal notice emphasizing that the law requires every individual to have a registered family physician. This is followed by a reminder that the same law also allows one to choose her/his family physician and grants them the right to change them as they please. Later on, it gives the whereabouts of this newly-opened FHC and states that they are in service of the patients "*with a caring and well-equipped personnel with a smiling attitude"*.

This emphasis on the smiling attitude of the FHC workers deserves a particular mention as it reflects the existence of this entrepreneurial character quite strikingly. During the interviews, many of the participants expressed that the patients are complaining about their neutral facial expressions, treating them as a sign of rudeness and disinterest towards them. The particular highlight put on the smiling attitude of the healthcare personnel in this respect points to a tendency to acknowledge this negative feedback on patients' side and include it as an extra quality of the services provided by the family physicians. An affective quality such as having a smiling and friendly attitude has been commodified here, hoping that it may constitute an attractive argument for drawing more patients to the newly opened FHC. An extensive list of services provided by the FHC has also been included in the flier, too. This comprises issuing every kind of medical report, taking care of visiting patients that have not been registered to the population, providing extensive obstetric services to the pregnant women, and so on. Some of those articles are also hotly contested by many participants during the interviews in many respects. However, one of them will be elaborated here further as it has been problematized by an overwhelming majority of the participants and provides a rich material enticing one to think about how the scope of medical services that a family physician could offer may become part of what constitutes an entrepreneurial identity.

The extensive authority of family physicians concerning issuing a wide range of medical reports for a large variety of situations ranging from getting a driver's license to the permission to carry hunting guns; from flying a drone to getting employed, is a significant cause of concern for them and it is strongly emphasized during the interviews. Their reservation for issuing those reports is rooted in their insufficiency as primary health care providers to judge crucial aspects of one's well-being, such as a patient's medical health or one's visual impairment, and insufficient health infrastructure that makes it even harder to make a judgment on those issues. Consequently, they do not want to draft those reports most of the time; as they are held liable for them in case of a litigation process where the respective report compiled by a family physician is put under scrutiny if potential malfeasance is due based on the

fact that it does not correctly address the relevant medical problem(s) causing the damage.

Most of the patients primarily consult their family physicians for obtaining those reports, though. When viewed from the perspective of a patient, it is much easier to apply one's family physician and having the required report after an insufficient examination imposed by the weaker health infrastructure of a primary healthcare institution; rather than going to a hospital and undergoing a relevant medical procedure revealing a more detailed and thorough picture of one's medical condition. As a result, the tension between the reluctance of family physicians for drafting those reports and the willingness of the patients for obtaining them through their family physicians create an intense conflict; providing the ground where the majority of the patients decide to switch to another medical doctor hoping that they would not encounter a similar level of resistance from their new family physician.

In light of that, the flier mentioned above gains a new significance that should be assessed in that context. The grey area instigated by the considerable authority granted by the ministry for issuing all sorts of medical reports to the family physicians; and the resulting reluctance caused by the bindingness of those reports creates a new opportunity for medical doctors in these virtual FHCs to increase their registered population. Ethically questionable aspects of that attitude left aside, the significant pressure caused by the concerns detailed above for those individuals incentivize them to market their medical authority allowing them to grant a larger number of medical reports as an appealing part influencing a patient's decision concerning choosing another family physician manifesting itself in the way the respective document has been formulated.

This vague field of action, enabling the family physicians who are working in the virtual FHCs to commodify their medical authority provides a clear proof of how entrepreneurial tendencies can become manifest under the regimen of the FHC model and how further competition could be enticed between family physicians working in different FHCs. However, this opportunity for further marketization of their realm of

authority in line with the principles of customer satisfaction is a great cause for concern for other family physicians with an already established population. As many of the participants emphasized, they feel threatened by the ever-increasing number of FHCs popping up in every part of the city without robust planning, including their neighborhoods resulting in dramatic losses in their population.

Aynur is one such family physician who had to both promote herself as part of a newly opened family health unit with zero population initially and compete with other colleagues who recently inaugurated a new virtual FHC in her neighborhood. *"I know that I have to get back to field now to reach new patients. I was just starting to think that I may be a bit comfortable now as I consolidated my population. But, they opened this new place in my 'territory' all of a sudden, and I lost the patients that I registered with great effort during the last three years,"* she complained. When asked about the potential reasons for her shifting population to other family physicians working in the newly-opened FHC in her neighborhood, she replied in a quiet, somber tone: "*As family physicians, we are not doing rocket science, to be honest. All of our friends provide pretty much a similar medical service to our patients. Those who change their family physician do that mainly because you don't submit to their will as they ask you all sorts of medical reports or want you to prescribe medicines that you deemed unnecessary. Attracting those patients require promising them to do what others don't most of the time."*

Her narrative is quite telling in revealing this dynamic as she builds her argument quite empathetically about the particular position occupied by herself. At the beginning of her career, she tried to increase her population by employing more or less similar strategies. However, she is more in a defensive situation now. She tries to protect her registered population from a significant loss tied to the promises made by other family physicians trying to increase their population. Interestingly, this heated competition between family physicians is framed mainly by a rhetoric reminiscent of a heated battle carrying even underground connotations at times. Words such as *"territory," "fight," "struggle," "stealing patients"* have been frequently mentioned by various participants during the interviews, pointing to the elevated nature of the

competition between family physicians. This heated competition seems to be only accelerating in the near future, considering that the number of virtual FHCs tends to inflate at an ever-growing rate throughout the country, especially in larger metropolitan areas.

However, maybe more significantly than that, this narrative also points to a more dominant tendency compatible with an entrepreneurial subjectivity but cannot be solely explained by that. This can be formulated as reinterpreting the professional ethos and the medical duties more in line with the demands of their patients. This is compatible with an entrepreneurial logic because meeting a patient's needs serves as a guarantee for keeping the number of the registered population intact for the family physicians as this translates into a steady level of income. As a bold claim, deserving a more refined analysis and requiring more focused research, this can also be interpreted as customer satisfaction replacing the health care provision as the main focus of primary health care providers in Turkey. Nevertheless, it reveals the significance of delving further into how the patient-doctor relationship has been reframed by the FHC model and how it is severely problematized by the participants during the interviews.

4.3. Shifting Authority in Patient-Doctor Dynamics and the Neoliberal Subjectification

Even though one side of family physicians' story with their patients involves an idealized execution of their profession despite the undeniable existence of an increasing competition between family physicians, as is explained in the preceding sections, the overall picture seems to be much more obscure. Most of their narratives concerning the everyday implications of doctor-patient dynamics reveal varying problems that should be addressed here. Although the doctor-patient relationship has been problematized in various respects in their descriptions, it should also be remarked that their complaints concerning their relationships with their registered population are first and foremost grounded on the shifting power dynamics between family physicians and the patients where the demands of the patients have been prioritized above all.

This common opinion is accompanied by a familiar feeling discernable in more or less each of their narratives, channeling them to evaluate their position less worthy and experiencing their medical authority as under threat.

The high level of disillusionment towards the evolving character of their profession, is most evident on two occasions where the dramatic consequences of shifting authority in doctor-patient relations are observable in its most apparent. These are the right to choose one's family physician and file a complaint about a doctor if one does not feel satisfied with the way she/he was treated by a respective family physician. Those two current practices have been unanimously framed in a negative, even hostile tone occasionally by nearly all of the participants; not only because they disrupt the power relations between doctor and the patient on behalf of the latter, but also makes them question their professional subjectivity and their subjective position within the health care system.

In the preceding sections, the right to choose one's family physician has been elaborated as a legal regulation introduced by the FHC model and the different ways the participants frame this new measure from their subjective positions. However, the evaluation of this dramatic novelty regulating a family physician's relations with her/his population is never complete without considering its further implications in everyday encounters of family physicians with their registered patients. Before delving into how this novel measure and its repercussions have been reflected, a short introduction concerning how the State has regulated the use of that right by the patients is necessary to make better sense of the participant's narratives and how they can be related to the formation of a neoliberal subjectivity for both patients and family physicians alike, within an antagonistic but reciprocal association with each other at the same time.

In the current model, individuals hold the right to change their family physician every three months as regulated by the State. Three different ways have been identified to realize that operation in the current body of law. The first option requires an individual application to the demanded family physician visiting her/his office and

filing an application form. The second option involves applying to the respective District Health Department where the family physicians' current workplace is located. The third and final choice is a recent addition and introduces an online application process as part of the current digitalization of the State services. An online platform called *"e-nabız,* merging a wide variety of health services under the same medium and enabling Turkish citizens to manage their healthcare-related affairs such as doctor and vaccination appointments, reaching former medical reports and images such as radiograms, sonograms etc., allows them to switch to another doctor quickly without being physically present in the FHC or in any other institution.

The ease of changing one's family physician is a primary source of disturbance for most participants in this study and they claim that their stance can be generalized for the rest of the family physicians, too. They are particularly concerned about introducing an online option as they completely lost track of their registered population after a certain point. Having no say in this process where patients are unilaterally privileged over this choice concerns them as they feel their authority to be threatened by this. *"Before this online option was available, a patient was coming to me in the first place, and I had a say in this. Now they come to me saying that they are a new patient and I don't have any authority to decide,"* says Canan in a way summarizing this common stance in her narrative.

An even more alarming trend following the introduction of *"e-nabız"* as an online medium to transform the nature of formal procedures lies in the strategic use of this easiness by their patients. As most of the participants already claimed that one's decision to switch to another medical doctor is mainly rooted in their willingness to find someone who would prescribe the medicines they wanted, including the frequently demanded antibiotics as the use of them and that is held exclusively liable to the authorization of medical doctors. Getting every kind of medical report easily through an appointment with their family physicians is another significant motivation, too. In the preceding sections, some of the family physicians have complained about the unethical tendencies of their colleagues, marketing their medical authority and the use of it for such situations as a selling point. However, it is essential to emphasize

that the demand and the supply work concomitantly in this case as patients are aware of such differentiation between family physicians and start to act strategically, benefiting from the easiness of changing their medical doctors. Selim's narrative reveals how far this strategizing tendency could go when this supply and demand meet each other as follows:

> *"Some of my patients know that I have rigid rules concerning issuing a medical report as most of the time I send them to hospital as the infrastructure of the FHC and the limits of my specialty prevent me giving that report to them. However, they are well aware that family physicians are giving these reports very easily as they may overlook the ethical aspect. On the other hand, they are also happy with the medical service I provide to them, and to resolve this problem, they switch to another family physician for three months and get their report, and after these three months, they switch back to me."*

It should be noted that this is not a singular example, and similar narratives can be encountered within the interviews reflecting patients' flexibility attitudes towards choosing their family physicians, showing the strength of respective changes in the material conditions of the implementation of some of the regulations and the power of digitalization in shaping the patient behavior. A seemingly technical novelty such as introducing a digital affair may result in a dramatic shift concerning the patient-doctor dynamic in the FHC model, in that respect and may start to threaten the medical authority of family physicians in initially unforeseeable ways.

As patients are highly aware of their newly earned power based upon the new regulations such as the right to choose their family physician as they please without further questioning of their choice, they mostly do not shy aware from turning their privileged position a matter of negotiation in their relationships with their respective family physicians as the participants highlighted boldly during the interviews. As their narratives pointed, the sentences such as *"if you don't do what I want, I switch to another physician*," "*I am your source of income, so you should treat me as I demand*," *"Will you do what I want or do you want me to drop you?"* is frequently employed

by the patients in a highly self-conscious way of their power over medical doctors in that model. Even though the family physicians who have relatively a higher registered population could resist the unethical demands of their patients to a certain degree, those who have been pressurized by their lack of an adequate population allowing them to earn a sufficient income to fend for themselves and their families may submit to the will of their patients most of the time as the participants claimed.

All of these examples are crucial to understanding how central the concept of patient satisfaction has become in the current implementation of the family medicine model in Turkey as it operates almost in a way that can be reformulated in the veins of "customer satisfaction" discourse where the famous motto *"The customer is always right"* is about to become increasingly an unavoidable reality for the everyday lives of family physicians in Turkey. It is also critical to note that the economization of the very relationship between the patient and the family physician by the patients themselves is a vital sign proving that the FHC model not only serves to the neoliberal subjectification of the family physicians but it also contributes to the formation of a neoliberal subjectivity on the side of patients as calculating-selves seeking for deriving further benefit for their respective position and use their privileges granted by the FHC model within the boundaries of a market-oriented mentality.

Another dynamic of patient-doctor relations within the FHC model that can be interpreted along the same line is the introduction of the right to file a complaint for patients in case they are not satisfied from the medical services provided by the family physician. In the current model, the patients are incentivized to give their feedback within a complaint mechanism created by the State in parallel with introducing the FHC model. There is a hotline called "184 SABİM report line" identified exclusively for that matter. There are also online channels where one can file a complaint about their family physicians. In addition to that, the newly introduced *"e-nabız"* application also provides the chance to evaluate medical doctors' performances working in every Turkish health system, including the primary health care providers, within a five-grade scale and leave their specific remarks detailing their feedback.

The existence of numerous channels to evaluate the performance of medical doctors and the right to complain about the provided medical services can be read as a sign of approval on the side of the State legitimizing the customer satisfaction discourse. It should be strongly emphasized that these channels are not arbitrarily created as the State actively encourage the individuals to present their opinion on the provision of health care services in an evaluative framework and tries to activate a dynamic where the quality of medical services are grounded on the basic principles of customer satisfaction as it is briefly touched upon above. An illustrative example pointing towards this current tendency can be found in the pandemic management of the State. From the very beginning of the COVID-19 pandemic in Turkey, family physicians have been responsibilized for calling the patients carrying the virus, on a daily basis, whether registered or not; and assisting them with their healthcare condition. Family physicians are also responsibilized to check whether COVID patients leave their houses or not to contain the further spread of the virus. A participant's statement detailing that how he had to contact the patients even during the eid-el-adha holiday is a strong narrative concerning the heavy burden undertaken by the family physicians during the pandemic that is still ongoing.

The biopolitical connotations of this practice left aside; there is a critical aspect to be mentioned concerning the disciplinary implications of this virus containment policy for the family physicians. Many of the participants stated that the MoH officers make random calls to the patients to check if the family physicians have reached them at the end of the day. If a COVID patient answers these questions non-affirmatively, she/he has been informed that a complaint request can be generated on behalf of the patient charging the family physician for neglecting her/his duties. This active incentivization policy encouraging the patients to evaluate the performances of the health care providers regularly is a strong indicator proving that this is a top priority on the side of the state to oversee the accountability of health care providers as the patient's satisfaction being the crucial indicator once again.

However, the operationalization of this dynamic, should be analyzed in conjunction with its everyday repercussions in the lives of both patients and the family

physicians alike. First of all, one should underline the striking similarity between the right to choose one's family physician and file a complaint about one's family physicians in its implementation for both parties. An overwhelming majority of the participants states that the execution of the right to file a complaint operates pretty much within the same rhetoric with the right to choose a family physician. Both of them are used and occasionally abused by the patients as a trump card against their family physicians to grant some of the medical reports tackled more in detail in the preceding paragraphs and sections economizing the patients' subjective conditions, in that respect. However, it should be also underlined that this is not a unilateral dynamic as the neoliberal subjectivities of both parties clash in these situations, and each side develops its strategy to benefit from the current conditions proving the potency of the neoliberalizing discourse on the personal level for all parties involved.

Another point that should be emphasized concerning the evaluation of those complaints by the State points to a different aspect of this mechanism, strengthening the patients' authority considerably. Many of the participants highlighted that when a patient filed a complaint for whatever reason, the respective physician to whom the complaint has been directed is contacted by the MoH demanding her/him pleading concerning the objection. As specified by the family physicians, the content of those complaints mainly involves extra-medical concerns such as keeping a patient waiting for a long time, not providing a courteous service to the patient, etc. The extra-medical nature of those complaints primarily results in dropping the subject unless serious harm rooted in malpractice occurs. However, the patients have been contacted after filing their complaints, anyways. The individual complaint and the testimony of the family physician concerning the subject have been evaluated together by the MoH, notifying them how their complaint has been finalized. Most participants claim that the patients have been reached by the ministry and notified that their family physician has been warned and the same situation would not be multiplied.

A significant portion of the participants declared their discontent for this practice as a substantial amount of them specified that they find it somewhat insulting to be treated that way by the patients and the State. In that respect, the family physicians are

not judgmental for this practice in itself as they support a healthy supervisory mechanism in case of a potential medical malpractice as they formulate the primary premise of the medical profession as not harming their patients, no matter what. However, they complain about the arbitrary nature of the current practice as all complaints are directly reflected to them without any preliminary examination questioning the foundations of the incoming complaints. The participants widely cite a recent example that can be interpreted as a caricaturized incarnation of their point of view during the interviews. This anecdote, covered by the national media outlets extensively as well is about a patient complaint involving the refusal of her family physician to prescribe a medicine for her dog (Kadıoğlu, 2021). The family physician declined the demand as he is not authorized to prescribe medication for animals. However, after the respective patient filed a complaint through online channels, the MoH opened an investigation to the family physician asking him why he refused to say that he was not a veterinarian.

This is mainly interpreted as a dramatic example showing how strong the customer satisfaction discourse could become in the evaluation of family physicians recently, as even the rejection of an absurd demand could appear as a possible inquiry of investigation. Accompanied by the fact that these complaints have been mostly contained in a way approving the patients' position and creating a perception that the State authority has warned the family physician, most of the participants think that this is damaging to their medical authority and a source of great anxiety for them that is highly visible in their narratives. *"They file an investigation on me asking me why I haven't prescribed such and such medicine upon the request of a patient. That makes me question my very existence as a medical doctor. If I cannot decide what medicine to prescribe to my patient, what am I doing here as a doctor? Or if I am to prescribe the medicine, is that going to make me a good doctor? The State thinks so, obviously,"* says Halide as an example where similar ones can be encountered occasionally during the interviews. This threatening tendency for their medical authorities and the increasing frequency of incoming complaints are framed within a sense of resistance as most of the participants claimed that they do fight with that *"unlawful"* practice and

try not to fall prey to the increasing dominance of customer satisfaction discourse in the primary health care provision.

"I know that I do the right thing as a doctor when I reject certain demands of my patients as this contradicts with the deontological foundations of the medical profession that I've learned during medical school. As long as I am confident about the way I perform my profession, I can do what I do with a clear conscience. I try not to care for the rest," Veli says in a symbolic way reflecting the typical stance of the participants in this study. However, an overwhelming majority of the family physicians interviewed also admit that they can be forced to act in compliance with those measures and start executing their profession more in line with patients' demands as the forthcoming pressure grows each day for them. It is important to note that they do not tend to blame their colleagues for submitting to this customer satisfaction discourse as their positions have been precarized by the measures such as population pressure resulting in this market like structure where patients can choose family physicians who develop an entrepreneurial subjectivity and accord their behavior concerning their patients' demands over the ones who insist on framing their medical profession and their respective medical authority more in the traditional lines. Their criticism is mainly directed to the foundations of the system as such, pushing them to embrace a more entrepreneurial identity by the fear of losing their patients and relatedly to that, their income.

However, it should also be pointed that the formation of a new subjective tendency can also be observed for some of the participants urging one to think further how varying implications of these practices can provide the potential seeds of an agency where family physicians discover an empowering aspect of their current situation amidst a thick cloud of despair dominating their narratives. To understand this subjective tendency better, one should look at how the participants themselves frame it. In that respect, the narrative developed by Tuğçe provides a clear picture of it.

> *"Up until recently, we were intimidated by the frequency and intensity of those complaints as we had to face a new investigation nearly every week concerning*

some sort of patient complaint. We were afraid because we thought that it could endanger our livelihood. However, as time went by, we understood that nothing serious would occur as long as we were confident. We also started to acknowledge the opportunities provided by our respective positions. During the first years of the FHC model, we continued to work with a strict civil servant mentality causing us to fear the State and the MoH. However, we recently realized that nothing happens if we ignore those investigations opened by the MoH because we are not in a hierarchical relationship with the ministry. It took us some time to adjust our new conditions, but now we know that we can develop a passive resistance that way."

Even though her statement cannot be generalized for the rest of the participants as for most of them those mechanisms are still a great source of distress, there can be encountered similar examples during the interviews where family physicians started to frame their subjective condition in a way offering them solutions to their problems allowing them to develop some sort of agency within the family medicine model. Even though the validity of this claim needs further attention as it requires a careful examination of the development of their medical career as family physicians in a broader context, it is a clear sign that family physicians as the primary addressees of the FHC model, concerning the operationalization of the family medicine model, may not be evaluated as passive subjects falling prey to the vicissitudes of the current FHC model but also active agents who could turn things around in their favor even when the conditions seem dire for them.

4.4. Conclusion

This chapter is derived from the narratives of the participants accentuating the transforming aspects of their relationships with their patients within the FHC model. First of all, the novel legal framework redefining the doctor-patient relationship under the family medicine model has been elaborated briefly. After revealing the constitutive dynamics of this relationship have been clarified, the way the idealized doctor-patient relation and its everyday reflections has been briefly discussed. The formation of

competing tendencies within family physicians have been touched upon thoroughly within a separate section detailing the prerequisites of that competitive environment emphasizing the asymmetry between family physicians concerning registering a certain number of patient under their names. The chapter ends on a pessimistic note from the standpoint of the participants as overall shifting power dynamics between family physicians and the patients have been developed here.

Discussing the neoliberal subjectification process and how it affects and got affected by the redefined nature of doctor-patient dynamics necessitated mentioning patients' subjectivities as much as those of participants. It should be emphasized that the sphere of influence neoliberal discourse and policies exert over the individuals is not only limited to a professional group but its diverse implications can be found in almost every individual on varying degrees. In that respect, the main premise of a neoliberal subjectivity that is formulated as "*everyone must learn to become an 'active' and 'autonomous' subject in and through the action they must perform on themselves"* (Dardot and Laval, 2014, p.268). To that end, it must not be overlooked that the doctor-patient relations in the framework of the FHC has been transformed within a neoliberal discourse meaning that each party evaluates the other side as a possible business partner.

The prerequisite of reformulating this traditional relationship in lines of a business relationship the subjects must treat themselves *"as though they were a business"* (Gershon, 2011, p.539). It should be mentioned that especially participants' narratives of an idealized family medicine model and the examples that may be drawn from these can be interpreted in that vein. Family physicians mostly acknowledge that they should develop other qualities along with their classically defined medical duties under the regimen of the FHC as they should have more cordial and cooperative relationships with their patients to be able to serve as medical assistants who are helping out their patients to improve their lives. As Dardot and Laval specifies quite elegantly, *"The qualities to be developed by the subject (…) refers to a social universe where 'self-representation' is a strategic issue for the enterprise. If it is obviously necessary to be 'open', 'synchronous', 'positive', 'empathetic' and 'cooperative', this*

is not solely for the sake of individual happiness, but firstly, and above all, so as to obtain from 'collaborators' the performance expected of them" (Dardot and Laval, 2014, p.272).

From that perspective, the close relationships that participants of the study interpret to be central while executing their medical duties cannot be only grasped within a humane perspective but should be understood as a strategic alliance between the doctor and the patient. This can be better conceived when one chooses to focus on the negative aspect of that relationship as the positive and idealized examples only cover a tiny portion of their relationships with their population. If the priorities set by the patient within their relations with their physicians is not determined on the basis of an improved health condition overall, but obtaining some quintessential documentation where the family physicians has been authorized to issue such as medical reports, the ethical stance of the participants may clash with the desires of their patients translating into the very definition of a corrupted and avoidable affiliation with their patients.

However, as there is a high degree of competition between family physicians to preserve their populations and registering an optimal number of patients under their name, it is claimed that there are many family physicians submitting to every demand of their patients. Most of the participants evaluate this kind of affiliation with their patients within an ethical discourse where the quintessential principles of the profession have been breached by some of their colleagues. However, from the standpoint of neoliberal subjectivity; where *"every relationship is a business relationship, some based on shared collective traits and others based on goals perceived as mutually satisfying"* (Gershon, 2011, p. 540), transgressing the traditionally defined ethical principles by some of the family physicians can be seen on a new light where two businesses come to terms on an agreement benefiting both parties in different ways. In this case, the family physicians choose to submit their patients' will not to lose their income as the patients may decide to switch to another family physician otherwise.

Even though the patients are singularly treated as possible business partners assessed in their likelihood to cooperate with the family physicians to give rise to the formation of an idealized experience of family medicine model, cumulatively they are formulated as a population perceived as an asset that should be managed and regulated as much as possible. Because an extensive array of new rights has been granted to the patients such as choosing their family physicians and switching to another one when their demands are not fulfilled by their respective physicians, right to file an official complaint through different media, grading their family physicians on a scale out of five and leaving online comments evaluating their consultation with their family physicians; acquiring a problem-free population appears as a top priority for most participants resituating the urgency to create friendly relationships with their patients. In that respect the effects of evaluative measures can be elaborated from another aspect as stated by Dardot and Laval. For them, neoliberal logic imposes a subjective position where the subject's value is not rooted in her/his inborn qualities or educational or professional credits but is directly linked to the measurable aspects of his performance through an extensive quantification of her/his labor (Dardot and Laval, 2014).

These extensive evaluative mechanisms on the side of family physicians are giving rise to a discourse shift in their treatment of patients expressing itself most visibly in the creation of a "customer satisfaction" discourse. Even though shying away from treating their patients as customers, it was a common occurrence on the side of family physicians using the word 'customer' instead of 'patient' before correcting it immediately to the "right" version from their ethical affiliation with their profession. This, alone, serves a proof showing the strength of a commercial ethos in framing their relations with the patients. Despite complaining about a misconstrued quantification of their labor; participants, nevertheless, feel forced to act in accordance with the demands of their patients to fill out the norms sought after by their population. Accounting for other extra-medical qualities to the algorithm of the evaluation such as a friendly behavior, a smiling attitude etc., this new evaluative framework dictates a reinterpretation of the subject in the form of *"a collection of assets that must be continually invested in, nurtured, managed, and developed"* (Martin, 2000, p.582; quoted in Gershon, 2011).

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CONCLUSION

This study was the fruition of a three-year long project where the first seeds have been planted during the researcher's extensive reading on neoliberalism and governmentality literature centered around influential French thinker Michel Foucault's writings. When it first appeared as an amorphous idea, the COVID pandemic was yet to emerge as a catastrophic event, wreaking havoc on all around the world and especially on the healthcare systems. The traces of the pandemic and its subjective consequences regarding the participants will be mentioned at the end of this concluding chapter. However, it would be beneficial first of all, raking together the main lines of thought that have been evaluated all along this inquiry and resituating them reconsidering the theoretical axis of the study.

The neoliberalization of health was a predominant subject since the late twentieth-century in the academia of Turkish social sciences and public health studies. Following the introduction of the HTP, these efforts are accelerated to a great extent and every layer of Turkish Healthcare services has been framed within this neoliberal critic, including the neoliberalization of primary health care provision that is the primary concern here. A significant majority of them were meticulous efforts detailing the novel measures introduced within the HTP model in the contours of Marxist or institutional accounts of neoliberalism as has been briefly explained during the introduction. However, most of those accounts were grounded on macro narratives of neoliberalism treating the HTP as an all-encompassing policy shift that would irrevocably transform the provision of healthcare services in Turkey.

In such a climate where the macro-level analysis of neoliberalism dominated the way the HTP has been problematized, bringing a micro level analysis to the forefront was an immediate need to addressed as there was a considerable shortage in that respect, counting out a few notable exceptions mentioned earlier in the introduction. Doing that would require a much more nuanced theorization of neoliberalism, revealing the contingent character of neoliberalism playing out on existing institutions

in a subtler way than as has been claimed by more hegemonic approaches situating neoliberalism as a totalizing ideology and this is where the Foucauldian governmentality literature exactly stepped in, greatly helping to formulate the arguments of the study on the theoretical level.

Understanding why a Foucauldian approach to neoliberalism has been prioritized over hegemonic or institutional explanations of neoliberalism or even other micro approaches such as neoliberal requires a better grasping of the primary concern of this study in the first place. Explaining why the family physicians have been targeted as the main focus of the study is revelatory of both the study's theoretical axis and its internal structuring, in that respect. The introduction of the family medicine model as the overarching framework to the primary healthcare provision starting from 2005, and the identification of the family physician as the main agent of this model was one of the most substantial transformations that took place within the entire HTP targeting medical doctors. Employing the FHC model as the new standard of primary healthcare radically changed the nature of family physicians' working status, redefined their responsibilities as workplace managers and identified an exclusive reconfiguration for the doctor-patient transforming completely the way these individuals experienced their professional and personal lives in parallel with a neoliberal ethos.

Choosing the neoliberal subjectification as the main theoretical framework in that respect was inevitable at that point as the main focus of the study was from the very beginning was revealing the diverse ways this new working title affected the everyday existence of those individuals. A policy level analysis was not enough to that end, as it chiefly operates on a political economic stratum falling short on explaining the practical manifestations this policy shift implies in favor of an overarching narrative positing the neoliberalism as a totalizing hegemonic discourse and overlooking its contingent character as specified by micro-narratives of the neoliberalism. On the other end of the spectrum, a micro-level theorization such as the neoliberal assemblage theory could be attractive as it offers taking the material conditions into account while assessing the effects of neoliberalism on an everyday level. However, the challenging aspects of the fieldwork dictated by the pandemic

condition, preventing the researcher to be physically present in the participants' working environments and to make further observations on changing conditions of working in relation to their material conditions beyond their narrative claims obtained during the online interviews left choosing the Foucauldian approach as the most reliable theoretical affiliation over the others for the aims of this study.

The initial aims of the study and the theoretical approach framing it has necessitated employing a qualitative perspective for carrying out the research adequately as elaborating on the everyday manifestations of family physicians' novel professional identities in relation to the FHC model was only possible through a qualitative assessment of their narratives. A field study has been designed for implementing the research at that point based on the face-to-face interviews with the participants and workplace visits to ensure a certain level of participant observation within the ethical bounds of possibility, enabling the researcher to inspect more closely their daily routines in the FHC. However, before I entered the field, the COVID-19 pandemic took over the world by storm and radically changed the conditions of possibility for the study to be implemented the way it had been initially structured. At that point, there was no other choice but to look for other alternatives.

An online ethnographic perspective has become the main methodological axis for the research from the moment it became obvious that a routine field study could not take place in those conditions. As a half-hearted but compulsory concession dictated by the pandemic conditions, this online approach to the participants resulted in a much more insightful outcome than it was initially predicted. An online ethnographic approach enabled me to conduct online interviews via Zoom videoconferencing app during the weekend, in the evening and in the lunchbreaks of the family physicians who agreed to participate to the study. Reached out via snowball sampling as the fastest and most accurate solution; this flexible timing concerning interviews granted an access to the daily lives of the participants in a more intimate way than it could have been as the research would have structured upon face-to-face interviews. Seeing their interactions with their families, patients, auxiliary personnel and other colleagues during these interviews, emanating from the mediated nature of

the online interviews proved to be compensating, to some extent, for the participant observatory position of the researcher as the illusory effect of conducting these interviews channeled them to act more in their comfort zones as it was not threatened by the physical presence of the researcher.

The qualitative phase of the study has been completed between February and April 2021, covering twenty-one recorded Zoom interviews. The relatively belated and rushed out interview calendar was mostly due to the difficulty of finding an entry point through the field as most of the family physicians were busier than their usual, also based upon the challenges set by the COVID-19 pandemic. However, once the initial contact has been formed via ISTAHED, the rest followed suit quite quickly. The fact that the interviews are recorded audio-visually enabled me to provide a better assessment of their body languages as the expression of their emotional conditions could be reevaluated during the transcription of those interviews. It was one of the initially unpredicted benefit of employing an online ethnographic approach it could not have been possible to attain otherwise.

Based mainly upon the Foucauldian analysis of neoliberal subjectification developed by French academics Pierre Dardot and Christian Laval in their acclaimed oeuvre *"The New Way of the World: On Neoliberal Society"*, the subjective transformations that took place in the everyday lives of the family physicians following the introduction of the FHC model have been developed under three different chapters here. The differentiation between these categories pays regard to the significant ways the FHC model reshaped their subjective conditions, professional identities and everyday encounters in their workplace and regroups them concerning the spatial implications, the labor arrangements, and the professional inter-relations with colleagues and the patients.

In that respect, following a brief and concise introductory account setting out the theoretical boundaries of the study and how the fieldwork would fit in this theoretical framing, the second chapter mainly tackles with diverse ways the family physicians have been responsibilized through the FHC model. Several instantiations derived from

their narratives during the interviews constituted the backbone of the chapter here, as is in the rest of the study, as well. The participants have been asked various questions detailing the effects of novel spatial reconfiguration imposed by the FHC model, positing them as co-managers of the workplace alongside their colleagues and bearing them an extensive load of responsibility for running the place as opposed to the former model as they were simply charged as medical providers, more or less. Even though the content and their stand points were ranging on a wide spectrum concerning their level of compatibility with those novel measures, it was quite visible that their lives have been deeply touched by the obvious and further implications of this spatial restructuring transforming the nature of the primary health care provision dramatically for them.

This chapter is a detailed account delving into the intensive spatial responsibilization of family physicians under the FHC regimen turning them into the managers of the place by bearing them with diverse liabilities ranging from paying their rent, bills, personnel costs, other expenses such as consumable materials and the medical equipment all necessary for running the FHC smoothly. Even though most of the participants locate themselves within a critical distance with these novel spatial requirements as most of them think that it is not up to them to take care of these as medical doctors, we also witness that a significant portion of them embracing their novel positions as they enjoy an increased amount of autonomy with their decisions. The main point to be emphasized here is the fact that although participants of the study are mainly critical of their current situation, it is still possible to catch glimpses of a subjective position where the general traits of a neoliberal subjectivity has been highly internalized. This proves that despite the strength of the deontological ethos manifesting itself repeatedly in the way they frame their spatial liabilities, the dynamics of neoliberal subjectification could still infiltrate through their subjective existence.

Another crucial point that should be emphasized concerning participants' narratives on their spatial responsibilization is how the effects of the former CHC model could still be observed in the way they resettled their responsibilities in a shared

way. Even though each of the family physicians have been granted a separate monthly allowance in the FHC model to take care of their responsibilities, the fact that most of the FHCs throughout the country still operate as multi-unit primary healthcare institutions as it was back in the day where the dominant model was still defined as the CHC. This multi-unit structure inherited from the former model enables study's participants to act jointly while handling their responsibilities yielding them to save further from their monthly allowances translating into a higher monthly income. Although this serves as a limiting mechanism to their highly sought after autonomy as is interpreted by some of the participants, the way the inherited aspects of the old primary healthcare service provision has been reinterpreted by them through an extensive economization of their selves shows how they can creatively reframe their existing conditions within a neoliberal subjectivity.

The third chapter is mainly revolving around understanding the subjective effects concerning the substantial alterations that took place with reference to family physicians' labor arrangements on a legal plain. The loss of civil servant status and the contractualization of their labor, the accompanied and seemingly contradictory obligation of employing auxiliary personnel rendering them employers at the same time, the transition towards a flexible wage regime determined by the indicators such as performance evaluation measures, the precarization of the traditionally ensured labor rights such as taking a paid leave of absence, and the related changes regarding their relations with their co-workers has been problematized during the chapter. Their narratives covered both expected outcomes and also unexpected results contributing to this study in unforeseeable ways before starting the field work.

The way these new labor arrangements have been experienced by the participants is expressed within a deeply-felt narrative of vulnerability in general. The negative performance evaluations and a flexibilized working regime is among the points that have been extensively pointed by the participants, in that respect. Resulting narrative of isolation from one another concerning the colleagues sharing the same workplace highly resonates with the further individualization in the framework of neoliberal subjectification process channeling one to own both her/his success and

failure. However, the claims on further autonomy have been also frequently mentioned, especially regarding the further responsibilities that adorn them with an employer title allowing them to choose whom to work with. However these contrasting narratives expressing both vulnerability and increased autonomy at the same time within same individuals result in a split subject manifesting itself most visibly what is called *"employer-employee"* dilemma by the participants. Within that narrative they mentioned their stuck-out positions between the agentive affiliation marked by their status as an employer and the subjects of further control and constant evaluation on the other side of the spectrum.

Another crucial consequence that should be reemphasized concerning this chapter is the role played by the inherited institutional framework in the formation of their subjectivity. This can be particularly observed regarding the way they resolve the problems related to the scheduling of family physicians' leave of absence as the novel system imposed a severe pay cut on their wages if they cannot delegate their medical responsibilities to a colleague in the FHC while they are on leave. To cope with the vulnerability caused by this measure, family physicians chose to benefit from the habits internalized by the old institutional structure and co-sharing the registered patients of their colleagues when one of them opt for using her/his leave of absence in most cases in a way that has not been specified by the current legislature. Even though, there are some reservations concerning this practice as mentioned earlier during the chapter, overall it constitutes a crucial reminder on considering the effects of the inherited institutional legacy on family physicians' current subjectivities.

The fourth chapter chiefly tackles with the transformation of the traditional doctor-patient relations and the different ways the power dynamics between the family physicians and their patients have been shifted in favor of the latter group, interpreted overwhelmingly as a significant loss of medical authority within a customer satisfaction discourse as can be deduced from the participants' narratives. The exclusive nature of the patient-doctor relationship ensured by the introduction of the obligation of working with a registered population, the evaluative mechanisms overseeing the healthy functioning relation of this relationship through measures such

as the right to unilaterally change one's family physician in case of an unsatisfaction or the exclusive right to file a complaint about a family physician have been dealt with during the chapter and the way the participants have reacted and positioned themselves in the face of those novel measure have been tried to be grasped during the chapter.

The consequences of the study are processed thoroughly during the chapters, emphasizing their connection to the theoretical framework where they have been situated. However, there are some serious limitations that should be mentioned concerning the way the study has been conducted as required by the academic honesty. These limiting aspects of the study should be assessed under two different categories. The first one of them reflects more or less the technical difficulties in relation to the sampling issues, or the methodological constraints, whereas the second category focuses on the theoretical limitations and offers alternative pathways for conducting such a study for the forthcoming research on the field.

First of all, the conditions of the COVID-19 pandemic restricted the study to a great extent as face-to-face interviews with the participants could not take place. Even though conducting an online field study had its own advantages mentioned earlier, if I had a chance to do the same study once again where the current conditions of pandemic has been invalidated, I would definitely go for the face-to-face option as it would give me a more extensive access to the field granting me the chance to be physically present in the workplaces of the participants. As the spatial dynamics constitute an indispensable part of this study, observing the working conditions of family physicians on the ground could provide further advantages that cannot be figured out in advance.

Another limiting feature of the study was the demographically narrow scope of the sample, preventing me to generalize the corollaries of the study. Although, I had a more or less balanced sample constitution, it had some deficiencies worth to be addressed here. First of all, 21 is not a sufficient number to make meaningful comparisons between the different portions of one's study sample. Even though I had no quantitative objectives as it was always intended to be a qualitative inquiry , the

stark differences that I noticed between older and younger participants channeled me to think further on the varying attitude of different generations concerning their thoughts and framing of the FHC model. However, the imbalance of the sample population concerning their age halted me in that respect.

The composition of the respective population of this study's sample is obviously not suited to make general deductions valid for the entire population of family physicians. The fact that all but two of the participants were from Istanbul operates as a limiting aspect of this inquiry, here as geographical difference have been specified as an important variable by many of the participants in their narratives affecting the way the FHC model is experienced quite dramatically. However, as this would have translated into a study where a lot more family physicians should have been contacted and this was not feasible on researcher's side surpassing the means available in the study. However, conducting a study where the geographical differentiation of the FHC model could not have been accounted can be partially countered by the fact that most participants live and work in the largest metropole in Turkey, whose institutions are spread all around the city and covering a large demographics ranging from the poorest sections to the wealthiest neighborhoods, in that case.

The technical problems of the study left aside, one has to also answer to the visible theoretical limitations restricting the study to some extent as understanding the full scope of neoliberal subjectification may necessitate mobilizing other theoretical approaches serving the same purpose. In that respect three different approach should be addressed here. The first one of them, as is also specified in the preceding chapters, is the actually existing neoliberalism literature. Being one of the significant alternatives of the Foucauldian neoliberal subjectification theory, and compared and contrasted by many scholars along the way upon its compatibility with the Foucauldian literature (Barnett, 2005; Springer, 2012), the immediacy of referring to that literature is obvious, at least for the purposes of this study.

As the main focus of actually existing neoliberalism literature lies in accounting for the preceding institutional, regional and global dynamics to the equation where

neoliberal policies took over, this emphasis on the interaction between the neoliberal framework and the preceding structures is highly relevant in the case of the FHC model where the remnants of the former CHC model as the replaced primary healthcare provision model is still evident in many aspects of the current system. Even though the respective challenges in merging two approaches has been widely documented, it would be definitely an exciting endeavor to delve further into how the inherited institutions, regulatory frameworks, policy climates have been reflected on the current subjective conditions of individuals where neoliberal policies domination cannot be denied.

If actually existing literature provided one of the different ways this study could have been conducted, another theoretical approach in that respect would definitely be the neoliberal assemblage theory as it has the potential to enlighten other aspects of concerning the neoliberal subjectification of primary health care professionals that has only been briefly touched during the study. As born out of the need of avoiding *"deterministic, homogenous, and static accounts of social transformation"* (Brady, 2014, p.11), neoliberal assemblages "link neoliberal political rationalities with non-liberal rationalities, and they explore how neoliberal thought and practice is transformed across time and space" (Brady, 2014, p.11). One of the most distinguishing qualities of this approach lies in the fact that the assemblage considers how heterogenous elements such as *"human and non-human entities re drawn together, the ways in which relations between these entities hold and are sustained and the resultant effects for agency, power, and governing"* (Higgins and Larner, 2017, p.4).

This final emphasis on the juxtaposition of human and non-human entities together and its further effects on the agency of the actors emplaced in a neoliberal policy environment is of utmost importance for this study as the FHC is an environment where the changing spatial dynamics and the extensive use of technological novelties stand out as significant factors affecting the neoliberal subjectification process in a way that has not been addressed by the Foucauldian scholarship properly. Some of those examples have been shortly elaborated during the

study such as the effect of having one's private room resulting in an enhanced sense of individuality and privacy or the further effects of technological novelties such as the online registration to a family physician on the side of patents or the right to file a complaint or evaluating a family physician's performance through online media.

However, the number of those examples can be multiplied greatly as the spatial reconfiguration was maybe the most crucial aspect of the transformation of primary healthcare services. However, as I could not be physically present in any of the FHCs where the participants are currently employed, I had to limit my scope to their narratives. Still, it can be clearly noticed that the same study could have been structured in a very different way if the neoliberal assemblage approach would have been prioritized instead of Foucauldian literature of neoliberal subjectification. This must be strongly underscored as a guiding suggestion for avid researchers willing to discover the intricacies of neoliberal subjectification process on a different light than it was tried to be revealed here.

The final theoretical notice regarding the way this study has been conducted is the lack of considering the effect of neoliberal populism in the formation of the Turkish healthcare policies and the way the HTP took its final shape in a way *"the position of the medical profession as an important stakeholder in the institutional settings was weakened"* (Agartan and Kuhlmann, 2019; p.1410). As Agartan et al. rightfully argues the way neoliberal policies have been implemented may bolster the agendas of right wing populist leaders in countries such as Turkey even though the main content of those policies do not radically differ from their Western counterparts where neoliberal policies play out on a more liberal political ground (Agartan and Kuhlmann, 2019).

The populistic tendencies inherent in the current FHC model, especially concerning the restructuring of the patient-doctor relationship in a way strengthening the power position of the patient over the medical doctor resulting in a significant loss of medical authority on the side of family physicians have been strongly emphasized by the participants during the study. A quote by a speech from the then-prime minister Recep Tayyip Erdoğan in 2011 can be beneficial to frame some features of the

neoliberal subjectification process for the family physicians in the light of neoliberal populism studies. In that speech, Erdoğan, in a public statement during the opening of a hospital, stated that *"The era of doctors is over now"* (Milliyet, 2011). As reminded by several participants during the interviews, it shows that the family physicians are acknowledging the threatening potential of populist tendencies to their medical authority, as a group. In that respect, their constant emphasis on the formation of a customer satisfaction discourse can also be interpreted in a new light.

The last point to be evaluated in this concluding chapter concerning the shortcomings of the study should obviously mention the effects of the COVID-19 pandemic. It has not been included on the main body of the study on purpose as the ongoing nature of the event would have limited us framing it properly in such a study. It is also noteworthy to underline that the motives of being a medical doctor in the time of a deadly pandemic was mostly absent in participants' narratives as the question set did not directly involve any specific inquiry for evaluating the effects of pandemic on their subjective conditions. Nevertheless, the bits and pieces of a fragmented discourse detailing out how their professional identity has been affected by the pandemic can be found in the interviews influencing their subjective conditions.

The effects of the pandemic on the everyday lives of participants should be discussed together with the economic crisis deepened by circumstances dictated by the pandemic. Nearly all of the participants complained about the rising costs of medical equipment and daily consumables such as surgical masks or medical gloves four, even fivefold on some occasions. Most of them stated that they can barely make ends meet at the end of the month due to this dramatic rise and being a family physician is about to lose its sustainability in those circumstances as they cannot balance their budget and are forced to spend out of their pockets where their monthly allowance is not sufficient to cover their costs. A significant portion of them emphasized that they may also think of switching to another career if this situation perpetuates, revealing that the sustainability of family medicine model is strictly dependent upon a smooth working of the market economy where the costs are not fluctuated in such a degree.

Finally, the worsened conditions of family physicians during the COVID-19 pandemic; manifesting itself most clearly with rising costs of medical equipment and insufficiency of monthly allowances forcing them to make out of pocket payments affecting their incomes, increased working responsibilities tied to the pandemic containment policy and not getting compensated for their extra duties, not getting enough support from the MoH during the pandemic resulting in a sense of isolation have been translated into an organized struggle. The primary healthcare professionals including family physicians have decided to down tools during three days in May 2021 as decided by a union mandate. This is interesting considering that the discontent and difficulties of their job have been mostly contained within an individual discourse in their narratives during the interviews framing work-related problems as issues that should be resolved within a personal defense mechanism.

I have contacted with some of the participants after the completion of interview phase and asked them whether they would be participating to the strike action and all of them answered affirmatively stating that it is time to act together as personal initiatives no longer suffice their long-repressed frustrations for the shortcomings of the system affecting them negatively. This new development could possibly be read as a turn in their mostly individualized positions privileging personal interests over organized action forms as could be derived from the interview data. However, supporting such a bold claim necessitates evaluating these novel tendencies more thoroughly on the ground of a well-founded theoretical affiliation by future researchers. In that respect, the severe challenge set by the pandemic conditions and accentuation of their work-related problems should be followed closely considering their newly found desire for organized struggle in relation to their evolving subjective conditions. All in all, I wish that this inquiry would be considered as a solid contribution to the studies of neoliberalism in Turkey in general, and the studies of neoliberal subjectification to be more specific as an academic work that appeared in one of the most challenging times our humankind ever faced, shedding light to the subjective conditions of the unsung actors of the COVID-19 pandemic. Beyond its academic qualities and claims, this study is also a testimony to their lives. Without the

unconditional support derived from the participants, this study would never have felt completed.

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