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A Phenomenological Exploration of the Meaning of Family Physicians' Roles in Urban Chronic Illness Care in Indonesia

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ABSTRACT

Chronic illness management in urban healthcare systems is a critical issue in contemporary family medicine, where physicians face increasing demands to provide long-term, person-centered care. While clinical frameworks exist to guide chronic care, little is known about how family physicians subjectively experience and interpret their roles in such complex environments. Existing research lacks depth in capturing the lived meanings behind physicians' practices, prompting the central question: How do family physicians make sense of their roles in managing chronic illness in urban settings? This study uses a descriptive phenomenological approach to explore the lived experiences of twelve family physicians practicing in Jakarta, Indonesia, with an average of 9.2 years of clinical experience, through semi-structured interviews. Data were analyzed using Colaizzi's seven-step method to extract essential themes. The findings reveal four key themes: navigating fragmented systems, sustaining empathy under pressure, assuming roles as educators and advocates, and balancing ideals with systemic constraints. These themes highlight the moral, emotional, and relational dimensions of chronic care that are often overshadowed by institutional priorities. The results underscore the importance of understanding physicians' inner experiences to inform more humane, sustainable practices in urban primary care. This study contributes to a deeper, experience-based understanding of chronic care delivery and provides actionable insights to guide professional development programs, policy improvements, and future research into the emotional and ethical dimensions of frontline medical practice.

INTRODUCTION

In contemporary urban healthcare systems, the management of chronic illnesses has emerged as one of the most persistent and complex public health challenges. Chronic conditions such as diabetes, hypertension, and cardiovascular disease are increasingly prevalent in urban populations due to lifestyle factors, environmental stressors, and socioeconomic disparities. Within this landscape, family physicians play a pivotal role in providing continuous, person-centered care that bridges biomedical treatment and the broader psychosocial context of patients' lives.

In Indonesia, the prevalence of chronic diseases in urban areas has surged in recent years, with the 2018 Basic Health Research (Riskesdas) reporting that 8.5% of adults in Jakarta are living with diabetes and over 30% with hypertension, reflecting a pressing need for sustainable care models (Kementerian Kesehatan RI, 2018).

While advancements in clinical protocols and technologies are ongoing, there is limited qualitative insight into how family physicians in Indonesia interpret and enact their roles amid challenges such as fragmented care systems, high patient volumes, and varying patient expectations. These contextual pressures affect how chronic illness care is delivered on the ground, especially in resource-constrained urban health facilities. This gap necessitates a closer look at physicians' day-to-day realities to understand the nuanced demands they navigate when managing chronic disease.

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Understanding the subjective dimensions of how family physicians experience their roles in managing chronic illness is essential for informing policy, education, and practice. Their perspectives offer insights into how care is shaped not only by clinical expertise but also by relational, ethical, and contextual factors that are deeply embedded in everyday encounters with patients.

Given this context, there is a pressing need to explore the meanings that family physicians attribute to their professional responsibilities and interactions, particularly in the face of systemic constraints and human suffering. A phenomenological approach, which centers on lived experience and interpretive depth, provides a valuable lens through which to examine this phenomenon in a manner that honors the complexity and humanity of medical practice.

Research on the lived experiences of healthcare professionals—particularly family physicians—in managing chronic illness has gained increased attention in recent years. This growing interest reflects the recognition that medical practice is not solely a technical or procedural task, but also a deeply human endeavor shaped by interpersonal dynamics, emotional labor, and ethical reflection. In the context of urban healthcare, where physicians routinely confront high patient volumes, complex care coordination, and social inequalities, their subjective experiences offer critical insights into how care is delivered and sustained over time.

However, efforts to explore these experiences have often been limited by methodological constraints. Quantitative approaches, while valuable for identifying trends and outcomes, are typically insufficient for capturing the nuanced meanings, emotions, and ethical tensions embedded in daily clinical encounters. Even some qualitative studies tend to focus on surface-level themes or functional descriptions, lacking the depth needed to reveal the essence of how physicians understand and live their professional roles.

This methodological gap has led to a fragmented understanding of the physician’s role in chronic disease management, particularly in urban contexts where challenges are amplified by systemic pressures and patient diversity. Without an approach that privileges lived experience and the meanings derived from it, essential dimensions of care—such as empathy, moral responsibility, and relational continuity—remain underrepresented in the literature.

Given these limitations, phenomenology offers a powerful alternative by focusing on how individuals experience and interpret their world. Through a rigorous, experience-oriented lens, this study aims to uncover the deeper meanings embedded in the practice of family medicine as it relates to managing chronic illness in urban communities.

Current responses to the challenges of chronic disease management in urban settings have largely relied on standardized clinical protocols, efficiency-driven care models, and technological solutions such as electronic health records and integrated care pathways. While these practical approaches have contributed to measurable improvements in health outcomes and system coordination, they often neglect the subjective realities and emotional labor involved in the physician's day-to-day encounters with patients. As a result, the understanding of how family physicians make sense of their roles—particularly in contexts of chronic illness marked by complexity and human vulnerability—remains incomplete.

Studies using quantitative or outcomes-based frameworks are limited in their ability to capture the nuanced, relational, and interpretive dimensions of care. Even qualitative research often emphasizes surface-level descriptions of challenges and strategies without probing the deeper meanings that shape physician behavior and motivation. These limitations create a gap in the literature, where the lived, affective, and moral dimensions of primary care work remain insufficiently understood, particularly in the context of high-demand urban environments.

To address this gap, a phenomenological approach is needed—one that privileges first-person perspectives and centers on how experiences are embodied, interpreted, and made meaningful by those who live them. By adopting this lens, the study seeks to illuminate the underlying structures of meaning that inform how family physicians navigate their responsibilities, sustain their empathy, and construct their professional identities within the complexities of urban chronic care.

Previous studies have explored various aspects of chronic illness management, including patient compliance, systemic barriers, and the efficiency of care models. However, only a few have focused on how family physicians themselves experience and interpret their roles in delivering care, especially in demanding urban settings. Research that does address physician perspectives often lacks depth in capturing the emotional, relational, and ethical dimensions of their work. Theories of person-centered care and continuity in family medicine suggest the importance of understanding how care is lived, not just delivered. This study builds on that foundation by turning attention to the subjective, lived meanings of physicians' experiences.

To explore this phenomenon, the study adopts a descriptive phenomenological approach based on the philosophy of Edmund Husserl. This method was selected to uncover the essence of family physicians' experiences without imposing theoretical assumptions or reducing their meanings to functional outcomes. Through semi-structured interviews, the study examines how physicians construct, sustain, and assign meaning to their roles in managing chronic illness. This approach directly addresses the limitations highlighted in the previous section by giving voice to the inner dimensions of clinical practice. In doing so, it provides a deeper understanding of the human aspects of care that are often overlooked.

This article is structured as follows: The introduction provides context for the study and outlines the gap in current knowledge. The next section explains the research setting and presents the philosophical and methodological foundations of the phenomenological approach. This is followed by a description of participant selection, data collection procedures, and data analysis using Colaizzi's method. The results section presents the key themes that emerged from the data, illustrated with quotes from participants. Finally, the discussion interprets the findings in light of existing literature and offers implications for practice and future research.

RESEARCH METHODS

Study Design

This study employed a descriptive phenomenological design to explore the lived experiences and perceived meanings of family physicians in managing chronic illness in urban communities. The phenomenological approach was selected due to its emphasis on understanding subjective human experiences and its capacity to capture the essence of complex social and clinical phenomena. Descriptive phenomenology, grounded in the philosophical tradition of Edmund Husserl, was used to bracket preconceived assumptions and focus on the participants' direct accounts of their experiences. This design enabled a rigorous exploration of the phenomenon as it was experienced, described, and interpreted by those directly involved.

Participants

Participants consisted of licensed family physicians actively practicing in urban primary care settings and directly involved in managing patients with chronic illnesses. Inclusion criteria required participants to have a minimum of five years of professional experience in urban family medicine, with ongoing engagement in chronic disease management. Physicians with administrative-only roles or those not involved in direct patient care were excluded. Participants were selected using purposive sampling to ensure rich, relevant, and diverse insights into the phenomenon. A total of twelve participants were involved, comprising seven males and five females, with an average age of 42.6 years (range: 35–57). They were recruited from multiple urban centers across Indonesia, including Jakarta, Surabaya, and Bandung, to capture regional variation in clinical practices and organizational contexts. Most participants practiced in government-funded health centers or private urban clinics.

Data Collection

Data were collected through in-depth, semi-structured interviews conducted face-to-face in private settings chosen by participants, including clinics and private offices. Each interview was guided by a flexible interview protocol designed to elicit detailed narratives about their experiences, challenges, values, and perceptions related to chronic disease management. Interviews lasted between 45 and 70 minutes and were audio-recorded with participants' consent. Field notes were also taken to capture non-verbal cues and contextual factors. To ensure a safe and reflective environment, interviews were scheduled at times convenient to participants and conducted in a calm, confidential atmosphere. The interview guide was adapted from previous phenomenological research in family medicine, with minor adjustments to fit the urban healthcare context.

Data Analysis

Data were analyzed using Colaizzi's seven-step descriptive phenomenological method, which involves reading all participants' transcripts, extracting significant statements, formulating meanings, clustering themes, and developing an exhaustive description of the phenomenon. The analytic process emphasized the identification of essential structures and meanings, while maintaining fidelity to participants' voices. NVivo 14 software was used to assist in the organization and coding of data, enhancing the study's auditability by allowing for transparent tracking of analytic decisions, theme development, and coding consistency across cases. This contributed to the trustworthiness of the findings by supporting methodological rigor and enabling external review or replication of the analytic trail. Themes were derived inductively and refined through iterative comparison across participants, leading to the articulation of shared meanings that reflected the core of the lived experience.

Ethical Considerations

Ethical approval for this study was obtained from the institutional ethics review board of a recognized academic medical institution. All participants were informed about the purpose, procedures, and voluntary nature of the study. Written informed consent was obtained from each participant prior to data collection. Confidentiality and anonymity were ensured by assigning pseudonyms and securely storing data in password-protected files. The study adhered to the ethical standards outlined in the Declaration of Helsinki and complied with all applicable national and institutional guidelines for human subject research.

RESULTS

This study explored the lived experiences and perceived meanings of the role of family physicians in managing chronic illness within urban communities. The data were analyzed using Colaizzi's phenomenological method, and four major themes emerged from the participants' narratives. Each theme captures essential aspects of the physicians' experiences, motivations, and challenges in delivering care to chronically ill patients in urban settings.

Navigating Complex Urban Health Systems

Participants described the intricate nature of health service delivery in urban environments. They frequently navigated fragmented referral systems, inconsistent patient follow-ups, and overlapping institutional roles. These complexities often demanded adaptive strategies and strong coordination.

"In the city, patients come and go from different hospitals, clinics, even alternative healers. I often have to 'chase' their histories from different sources to get the full picture." (Participant 4)

This complexity positioned family physicians not merely as frontline providers but as coordinators and integrators of care, bridging systemic gaps to ensure patient continuity.

Sustaining Empathy Amidst High Patient Volume

The physicians acknowledged the emotional toll of maintaining empathy and attentiveness while managing a high volume of patients with chronic illnesses. Urban clinical settings, often overwhelmed and understaffed, challenged their ability to provide humanistic care.

"Some days I see over 50 patients, and many of them come with long, complicated histories. Still, I try to remember that each person is more than just a disease code." (Participant 7)

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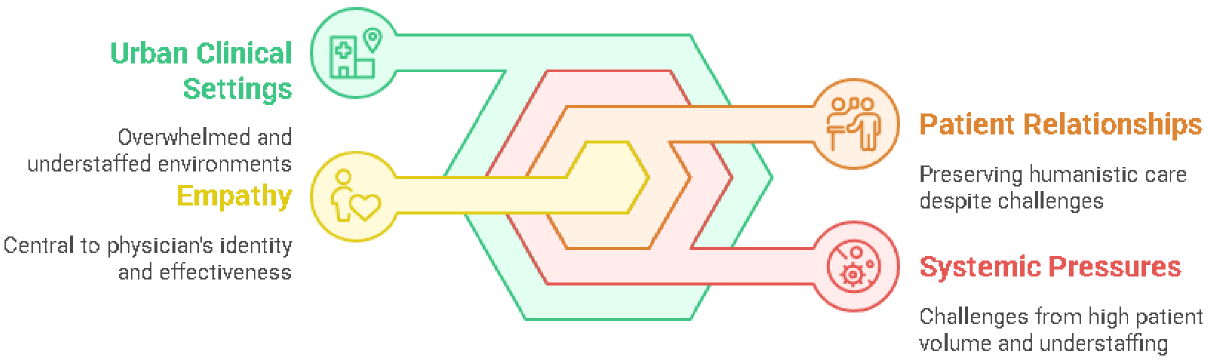
Despite systemic pressures, participants expressed a strong commitment to preserving empathetic relationships with patients, viewing it as central to their professional identity and therapeutic effectiveness.

Physician's Empathy in Healthcare



The Physician as Educator and Advocate

Many family physicians reported that they assumed the dual role of educator and health advocate—especially in communities where health literacy remained low. They described patient education as both a daily task and a long-term strategy for managing chronic conditions.

“I don't just prescribe. I explain—sometimes more than once. It’s not easy, but if they don’t understand what’s happening to their bodies, the disease will control them, not the other way around.” (Participant 2)

This educational role extended beyond clinical interactions and often involved community outreach or informal counseling during repeated consultations.

Balancing Professional Ideals with Systemic Constraints

A recurrent tension was evident between the ideals of holistic, continuous care and the bureaucratic or infrastructural constraints within urban health systems. Physicians shared how administrative burdens, insurance policies, and limited consultation time affected their ability to deliver ideal care.

“We’re trained to treat the whole person, not just symptoms. But the system counts how many patients you see, not how deeply you know them.” (Participant 9)

Participants highlighted the emotional burden of this misalignment, revealing moments of moral distress and professional frustration. Nonetheless, they maintained a sense of meaning by focusing on small victories and the impact they made in patients’ lives over time.

The findings reveal that family physicians in urban areas perceive their roles as multidimensional—extending beyond clinical expertise to include education, advocacy, coordination, and emotional support. Despite working in structurally challenging environments, they find meaning in relational aspects of care and in maintaining a person-centered approach, even under pressure. These roles are not just performed but deeply lived, shaped by the tension between systemic demands and personal commitment to patients' well-being.

DISCUSSION

Family physicians working in urban settings experience their roles in managing chronic illness as multidimensional, involving not only clinical expertise but also emotional resilience, patient education, and system navigation. These findings reveal the essence of their lived experiences: a constant negotiation between professional ideals and the realities of complex healthcare

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environments—directly addressing the central research question concerning how physicians make sense of their roles in chronic care.

The study offers a unique contribution by uncovering how family physicians interpret their responsibilities beyond biomedical functions. Rather than focusing solely on treatment protocols or patient outcomes, the findings illuminate the emotional, ethical, and relational elements embedded in chronic care management. Physicians perceive their role as both caregiver and mediator—bridging institutional gaps while sustaining empathy in time-pressured contexts. This deepened understanding adds a humanistic dimension to the discourse on chronic illness care, suggesting that physicians' meaning-making processes are central to the sustainability of care practices.

These interpretations align with existing theories on person-centered care and continuity in primary healthcare (Starfield, 1998; Mead & Bower, 2000), which emphasize the therapeutic value of long-term relational engagement between physician and patient. Consistent with Lupton's (2022) work on digital health and the emotional labor of caregiving, this study reinforces the idea that systemic demands often place strain on professionals' moral and emotional capacities. At the same time, it expands on previous findings (e.g., Greenhalgh et al., 2020) by highlighting how physicians maintain their commitment to holistic care, even when institutional frameworks undervalue those aspects. Thus, this study complements prior research by offering an interpretive account of how physicians derive meaning in spaces of constraint and complexity.

The findings from this study carry important implications for both clinical practice and medical education. On a practical level, recognizing the multidimensional nature of the physician's role can inform interventions that support emotional well-being, foster reflective practice, and promote relational continuity in chronic illness care. Socially and professionally, the study emphasizes the importance of preserving the humanistic elements of medicine—particularly in urban settings where bureaucratic and systemic demands may erode empathetic engagement. Understanding how family physicians construct meaning in their work can guide policy development that prioritizes not only efficiency but also relational integrity and practitioner resilience. These insights may be relevant to broader urban healthcare contexts, especially in regions facing similar structural and workload challenges.

Despite its strengths, this study has several limitations. The sample consisted of physicians from a specific urban health system, which may limit the transferability of findings to other geographic or institutional settings. Additionally, while the phenomenological approach provided rich, in-depth insights, it is inherently interpretive and context-bound, and does not aim for generalization. Language and cultural factors may also influence how experiences were articulated and understood, which is a consideration in any qualitative research. These limitations should be seen not as weaknesses, but as invitations for further exploration using diverse perspectives and methods.

Future research could build upon these findings by examining how physicians in different cultural or rural contexts interpret their roles in chronic care, potentially revealing new dimensions of meaning and professional identity. Longitudinal studies may also help to explore how physicians' sense of meaning evolves over time, particularly in response to systemic reforms or technological changes in healthcare delivery. Integrating phenomenological insights into interdisciplinary studies may offer a more holistic understanding of the physician-patient relationship, bridging the gap between individual experience and institutional design.

CONCLUSION

This study explored the lived experiences of family physicians in managing chronic illness within urban communities, focusing on how they construct meaning in their professional roles. The findings revealed that physicians perceive their roles as multidimensional, encompassing clinical care, emotional resilience, patient advocacy, and systemic navigation. These insights address a gap in previous research, which often overlooked the relational and ethical dimensions of chronic care in favor of procedural or quantitative outcomes. By applying a descriptive phenomenological approach, this study offers a deeper understanding of the human elements embedded in everyday medical practice.

The results may inform strategies for supporting physician well-being and improving the quality of patient-centered care in urban health systems. Importantly, these findings underscore the transformative potential of phenomenological insights to inform healthcare policy, medical ethics, and professional education, particularly in designing reflective curricula and resilience-building programs for primary care physicians. Future research should investigate how such meanings shift in response to systemic reforms or cultural factors and examine interventions that translate physicians' lived experiences into structural support. Healthcare administrators, medical educators, and policy-makers are encouraged to engage with these insights to co-create environments that nurture not only clinical competence but also the moral and emotional integrity of chronic illness care.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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