

Final Report - Hippocrates Exchange Programme

REPORT FOR LEONARDO EXCHANGE PROGRAMME WITH A GENERAL PRACTICE IN SPAIN

Grace Rollason, 3 October, 2011

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INTRODUCTION

I was fortunate to be awarded a place on the Leonardo Exchange programme for GPs in the first five years after completing their VTS schemes. The scheme was operating for the first time this year, so I was glad to be one of the pilots for the scheme, whose aim is to promote links between young GPs across Europe, to learn from each other and to increase interprofessional links and cooperation.

I have been interested in Spanish culture for many years, hence opted for an exchange for a practice in Spain. I hosted a GP registrar, Dr Laura de Sans Flores from a practice in Barcelona, for two weeks. I organised a mixed programme for her, so that she could spend time with all the different health professionals at our practice, and spend time with health professionals in the community and with the local GP training scheme so that she could gain a good overview of the NHS primary care health system. I then spent two weeks at the General Ricardos Health Centre in Madrid for two weeks in September hosted by Dr Santiago Machin who also organised a varied programme for me which enabled me to achieve my aims of taking part in the programme.

I wanted to take part in the programme for professional and personal reasons. I feel that for professional reasons it is important to learn from colleagues in different countries so we can improve our personal patient care and gain appreciation of the advantages and disadvantages of different health care systems that may enable us to change our own practice in the UK. I am also very interested in whether our 'Gold Standards' of care, routine disease investigation and management are the same in other countries, and if not, why not. I am also fascinated by 'the consultation' and wanted to see whether there were many differences in the disease presentation, health beliefs and the relationship between doctor and patient in the two different countries. On a personal level, I have had a love of Spain for many years so was keen to use my Spanish language and to gain a different insight into their culture and to understand the language they use when they attend the doctor. I took the opportunity to stay in a home stay, which gave me a further insight into Spanish life.

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The Spanish health system has a similar structure to the NHS in England in that it is free at the point of delivery and is paid for through the tax system; however there were many differences which I will examine further.

MY PLACEMENT AND THE DAY TO DAY RUNNING OF THE HEALTH CENTRE.

I was placed at the General Ricardos Health Centre in the Oporto Region of Madrid. It was an inner city placement at a large health centre of 30 doctors, and approximately the same number of nurses as well as midwives, community paediatricians, physiotherapists and dentists. Each doctor had an individual list of around 1500 patients; hence the total population was approximately 45000 patients, which is approximately twice the normal size of most health centres in Spain, as it was once two separate centres. The population was much more stable than that of my surgery in London, with little turnover. There was an influx of immigration approximately 10 years ago, but this has now stabilised and there is a large elderly population, who have lived in the area, either for their whole lives, or for many years, and whose children and grandchildren still live in the area. This means that the GP often knows the whole family which can be very useful for knowing the patient's social background, and there is much more family support. Patients often attend with other family members in the room, and also often attend in lieu of their spouse. I noticed that there was a much more lax attitude to confidentiality. If a patient had come in lieu of their relative, it was assumed that this had been done with the patient's consent, and the patient was discussed quite openly. However, when I discussed this with Dr Machin, he did assure me that he was aware of this and would never divulge information which the relative was not already aware of.

GPs in Spain have a much reduced variety in their patient population as discussed below, as they do not see children under 14, or pregnant and postnatal women. They do many less practical procedures such as smears, gynaecological examinations, and even chronic disease monitoring which the nurses do.

They have many less blood tests to check; these are not sent down line but are sent on paper which the GP then has to enter by hand. Unless there are any urgent abnormalities then the patient will only receive their results if they attend surgery. They are then routinely given a copy of their results to take home with them.

Communication with secondary care is less good than in the UK. If a patient attends A+E or attends a specialist, even if referred by the GP, there is no correspondence with the GP apart from a letter, often a handwritten note, from the specialist to that the patient is expected to take to the GP himself. This passes a lot of responsibility onto the patient for his own care and greatly decreases the communication between primary and secondary care. Again, it reduces the paperwork for the GP as he receives hardly any results or correspondence from the hospital. Referrals are done during the consultation, and are done online, with a very brief note to the specialist. Again this reduces paperwork greatly but means that referral letters are very brief and often do not contain much background information or past medical history.

The doctors work shifts and are either morning (8am-3pm) or afternoon (2pm-9pm)

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doctors. When a patient registers at a practice they have to choose to be under a 'morning' or an 'afternoon' doctor with whom they are strongly encouraged to stick with. This means that the doctors shifts are very inflexible as are the patients' choice of appointment times. They operate an individual list system although patients are able to see another doctor if an emergency and can change doctor if they are unhappy with a doctor. However, this does provide good continuity of care and the doctors are able to get to know their own patients very well, especially as they work every week day.

Doctors see around 40 patients in their 5 hour shift of patients, with appointment times being around 7 minutes. This sounds daunting, but patients seem to expect less of the consultation. They sometimes attend just for their prescriptions, or for their relative's prescriptions, for sick notes, which are needed even for one day off work, or for a print out of their health summary in case they become ill on holiday in another part of Spain. They do not seem to expect to discuss the management of the case and are usually accept the doctor's instructions with little discussion, although this was not exclusively the case. Patients expect to have to wait as the doctors usually run late. The overall consultation is less formal, the GP often knows the patient well, and will often tell patients off (usually with humour) for not having taken their medication or for coming back repeatedly with the same symptoms. The GP usually has his own nurse working in an adjoining room, the door to which is often left open even though the nurse and doctor are both consulting with different patients, again showing a less formal attitude to confidentiality.

The doctor and nurse have a close working relationship, and the doctor will often ask the nurse to do investigations such as a finger glucose test during the consultation. The nurses do nearly all chronic disease measurements, the patient then making another appointment to see the doctor to discuss the results. Nurses do a lot of primary prevention such as lifestyle advice, as well as injections, dressings etc. The GP refers the patient for nurse appointments even for things such as a MMSE, the patient again having to make another appointment to see the GP subsequently. Overall, although the GP appointments are shorter, there seems to be less pressure to do so much within the 7 minutes, with the doctor delegating to his health colleagues and the patients expecting to have several appointments for a problem that may well be dealt with in one in the UK.

There are no district nurses in Spain, the duties of whom are carried out by the practice nurses, who do home visits most days for housebound patients on the list of the GP that they are linked too, as well as for dressings, blood tests and ulcers etc. This provides very good continuity of care for housebound and elderly patients as the nurse and doctor work closely together for this group of patients.

GPs in Spain do not see children under the age of 14years old. Up to this age they see a community paediatrician who also works in the health centre. She does all baby checks, the first of which is 7-14 days after birth, then 1, 2, 3, 4,12months, 4 years, 6 years, 11 years and 14 years. These are opportunities for health promotion, vaccinations and developmental checks. To my eyes, this did seem a bit excessive, compared with our own system, but I can see their use. For example, the 14 year old check up involved talking to the child about the changes in their body, contraception, social matters such as being able to say no to their peers and sensible lifestyle choices. I am not sure what the evidence is for the proven health benefits of this but it did seem

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sensible. However, in Spain there are no health visitors or school nurses, so the paediatrician and her nurse at the surgery do seem to also take on these roles.

The paediatrician saw all cases that GPs normally see in the UK. For me, this would be a large down side to working in Spain, as it removes a large part of the variety of the GPs population. Although the paediatrician obviously had more paediatric training, she still had to refer the children to hospital for many of the same things that GPs would in the UK.

GPs in Spain also do little maternity care. This is mainly done by community midwives who work in the practice and by the hospital obstetric teams. The booking process is similar to the UK; they have scans at 12 and 20 weeks and also an extra scan at 32 weeks. They have 6 antenatal lessons under the health system. They are advised to take folic acid and iodine throughout pregnancy and breastfeeding period. They are routinely screened for Group B strep at around 38 weeks and are usually induced at 41 weeks. Home births are very rare but midwife led deliveries at the local maternity unit are being encouraged more and more. After delivery, the midwife does not do any home visits.

After a normal delivery, the patient attends the midwife at the health centre in the first 1 or 2 weeks after delivery, she can attend as soon as she likes if there are any problems. Access to the midwives is very easy as they work at the health centre every day, they do cover patients of other health centres as well. Breastfeeding rates are very high. It was interesting to observe the midwives checks after delivery. They are much brusquer with patients, doing a PV and examining the patients' breasts as routine.

Approximately 6 weeks after birth the patients start a programme of 6 post natal classes which include teaching how to start separating the baby from the mother to encourage independence, baby physiotherapy, discipline, weaning etc. Again, this does take on some of the role of the health visitor in the UK, but does provide an opportunity for mothers to socialise and to not feel isolated with any problems they have. It is also an opportunity for any social or development problems to be picked up.

Midwives also do all smears, including non pregnant women. GPs do not routinely fit IUDs; these are done by the gynaecologist. Some GPs are starting to insert contraceptive implants but they are still rare.

THE CONSULTATION

I was interested to see if patients presented in a different way from patients in the UK with the same conditions. The two weeks of the placement, in reality, was too little time to investigate this fully, but there were not many obvious differences. From my observations the process of history, examination and investigation to reach a diagnosis was similar, although on average, the history seemed to be more cursory, again this was often more possible as the doctors knew their patients so well so knew what was in and out of character. As far as investigations went I was not there for long enough to be able to ascertain any true differences in how they investigate illness. There were not any obvious differences.

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It was easier to make referrals, with a very short online note of the presenting complaint, past medical history, drug history and summary being sent to a central booking centre who would then ring the patient back with the nearest and soonest available appointment time. It seemed that less routine specialist care was managed in the community. Hospital doctors had a very strong reputation of not communicating well with patients, who would often come back to their GP for an explanation of the handwritten note that the specialist may have left with them. Referral rates between doctors were monitored, and they varied widely as here.

The overall consultation manner was quite different. There was little exploration of the patients' ideas concerns or expectations and the doctors were much more didactic. The patients seemed to expect this and rarely questioned the doctors much, but accepted the doctor's opinion. The doctor always sat behind a desk as a barrier. The overall consultation style was often more informal, with lots of jokes, often as the doctor had often known the patient and his family for years. The doctor would often tell the patient off for coming late, not taking his medicines etc. Consultation styles did vary between doctors but the overall style was definitely more doctor led, with the patients being more passive and seeming quite willing to hand the locus of control to the doctor. I did not sit with any GP registrars but it would have been interesting to see if their consultation styles were different, and if they had heard of any of the consultation models that we use in the UK, as the doctors I sat with had not heard of them.

MEDICATION AND PRESCRIPTION USE

The prescription system differed from that in the UK, with patients either being 'pensionistas' who did not pay at all for their prescriptions, such as elderly people or people on sick leave. Other people had to pay 40% of whatever drug they were prescribed, whatever the cost of that prescription. The prescription had to be printed on a different colour paper depending on the status of the patient which meant that it was the responsibility of the GP to know the payment status of the patient which is more awkward than in the UK. More people seemed to have to pay for their prescriptions than in the UK. I am not sure why this is, but the criteria do seem to be stricter there.

Prescribing habits seemed to be similar to the UK. There has not been such a culture of generic prescribing as there is in the UK, but to cut down costs a new rule has been passed meaning that chemists will check that all drugs have been prescribed as a generic unless no alternative is available.

I noticed that some medicines are used that are not used in the UK, such as arginine, which they often prescribe with ibuprofen. Also acetylcysteine was often prescribed as an expectorant. The doctor did admit that there was a lot of placebo effect in this prescribing. Some drug groups were used which I had never come across here, such as pirazalones. Antibiotic use was different due to the local different drug resistance.

THE ROLE OF THE FAMILY

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One major difference was that many patients attended with a relative or attended in lieu of a relative. Patients often made one appointment for themselves and another for their relative which they would use as an appointment to get his prescription for them.

The role of the family also seemed to be stronger in caring for elderly relatives. The extended family usually lived nearby and it was rare for an elderly person to be living alone with no relative nearby. One home visit was quite striking where with the nurse I visited a lady in her late 70s with end stage Alzheimer's. She was cachectic, although she continually demanded, and ate food, she was unable to walk unaided, and even seated in a chair would gradually slip to the floor. She was cared for by her daughter and granddaughter and her husband. She was strapped to her chair gently by two sheets so that she would not fall to the ground. She was well cared for by her family with no other home help. I have never seen such a level of care provided at home to a relative in the UK, and feel sure that such a patient would more than likely have been put into a nursing home.

PROTOCOLS, QUALITY MONITORING, AUDIT AND APPRAISAL

Another main difference between the UK and Spain is that the Spanish health system is separated much more distinctly into different regions. Each different region's health care system is quite distinct. You have to undergo a lot of bureaucracy to work in a different system, and each system has its own protocols policies and screening systems. I worked in the Madrid region so I can only vouch for the system there.

There were many chronic disease templates, as in the UK, but QOF does not exist so there was less incentive to fill these in religiously. Nurses usually used them most. There seemed to be less centralised protocols regarding prescribing, doctors often used NICE and other international recommendations, but prescribing of statins etc did seem to vary more between doctors in terms of specific choice of statin used.

Although there was not QOF, there was a list (Cartera de servicios estandarizados' of basic level of care that a patient should expect: 'Criterios de Inclusion'. Beyond this, there was also a list of 'Gold Standards' - 'Criterios de Buena Atencion'. There did seem to be some kind of audit of GP performance such as each doctor's referral rates, generic prescribing and attainment of gold standards, but the doctors were not very clear exactly what they were, as they had not been well communicated by the health board, and didn't feel that they were very incentivised by the small potential bonus that they would receive each year. Nurses and all other staff in the health centre were subject to the same kind of investigation.

I did not have a chance to find out about audit, but it was not apparent that much was occurring. There is no annual appraisal in Spain and no real checks on a doctor's performance apart from referral rates etc, as previously described.

THE ACCIDENT AND EMERGENCY DEPARTMENT (LAS URGENCIAS)

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I was fortunate to have the opportunity to spend a day in the accident and emergency department of the local hospital, Las Doce de Octubre, one of the largest teaching hospitals in Madrid.

In Spain, there is no 'Emergency Medicine' speciality and the A+E department is run by GPs who have branched off into that area. Children and pregnant women are seen in a different part of the hospital. An ophthalmologist, ENT surgeon, orthopaedic team, and psychiatrist are all stationed in the emergency department so any problem, even a minor one such as conjunctivitis or otitis externa will be seen by a specialist. The doctors working in the A+E department were able to admit patients without a specialist review so it would be interesting to see whether admission rates are higher because of this.

Patients seemed to attend with the same range of conditions as in the UK, with many minor illnesses that could be dealt with by their family doctor. Having a specialist in the department for ENT etc may have increased attendances in these areas. There was no 4 hour target, and waiting times were sometimes long.

CAREER STRUCTURE

The career structure for GPs in Spain seems to be much less flexible than that in the UK, there are less opportunities to develop special interests; it is more difficult to take a career break or to work flexible hours. The health centres are run directly by the state, so GPs are less involved in organisation decisions and are not free to run their practice as a small business or to develop services for their particular patient population.

CONCLUSION

In conclusion, there were many similarities between the Spanish and the UK health systems. They are both free at the point of delivery and are based on the Beveridge', with primary care being the first point of access to the system.

There were many small differences between consultation styles and the day to day running of the centre, although it was very apparent that apart from some cultural differences patients attend the GP for similar conditions and presenting symptoms and the basic ways of managing the conditions are very similar. On average, I agree with Hofstede's previous research (2001) that says that Mediterranean countries usually have a higher 'Power Distance Index', and are happy to accept what the doctor tells them, as a professional in power, are lower scoring on the 'Individualistic' criteria, with a strong family and community structure, value assertiveness and self interest less, and would have a higher 'Uncertainty Avoidance Index' with stronger religious and philosophical frameworks to deal with the uncertainty of illness, and are more outwardly expressive than in the UK. However, these are generalisations, and may well be changing as society in Spain is becoming more fragmented and individualistic as it is in Northern European countries.

One of the main differences between the systems is the lack of autonomy of general practitioners in Spain. They are much more restricted in their careers, being much more employees of the state directly than we are in the UK. I feel that this, as well as the lack of patient variety, would be a major disadvantage to working in Spain. However, the

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working hours with shorter on a daily basis and I felt that the individual lists and close working with the nursing staff was a major advantage to improving continuity of care and aiding the doctor's knowledge of the social context.

I would also say that patients, overall, were less demanding and more appreciative of their health system. I was told there is not a culture of suing and people, in general are fond of 'their doctor'.

I think that doctors in Spain could delegate more administrative work, and could improve communication with secondary care which would free up some of their consultation time. There was also a noticeable difference in consultation style, with less attention to patients 'Ideas, concerns and expectations' which did make the consultations less intense.

I think in the UK, patients should be made to realise more of the limitations of what a public health system can provide and we should be more able to set limits. For example, bariatric surgery is still much rarer in Spain, as there is not such a culture of there always being an easy solution, and often an external solution, to complex problems brought on by lifestyle choices. However, this is changing.

I really enjoyed my placement; it was a unique opportunity to have an insight into the workings of an alternative health care system and another culture. I would strongly recommend it to any other doctors who would like to broaden their horizons, especially if they have other languages.