

Hippokrates Exchange Programme - Final Report

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The exchange was a fantastic experience. I felt very privileged to be let into the lives, both at work and at home, of several doctors in Graz, and to be the first JAMO exchange doctor in Austria. I had forgotten the fraternity I had joined when becoming a doctor, a truly international one, with us all having a lot to learn from each other. I would particularly like to thank Julia Baumgartner, for coordinating the exchange and hosting me in her practice, Michael Wendler, for being so warm and welcoming, providing lots of great conversation to reflect upon and his family for their support, Ilse Hellemann, for showing me some new ways of working which I shall take back to the UK, and Walter Fiara for showing me how truly integrated complementary and allopathic healthcare can be done to such a high standard. I also highly recommend Graz, as having the right size community to feel welcome, a beautiful city and surroundings, good weather, and some great food!

I would like to start by discussing some small but interesting differences between Austria and the UK, in what I observed. I will then critique the health systems of the two nations. Finally I will discuss the development of medical education and training in General practice in Austria.

In the consulting room I noticed that many doctors still where a white coat, or at least a white polo shirt. This symbol has gone in the UK, but it does help make clear who the doctor is in the practice. There is the practice of changing clothes and shoes when at work. I am not sure of the evidence base for reducing infections but it does provide a clear separation of work and home life.

The patients certainly seemed more ready to undress, and where there are practices with spare examination rooms, patients would often go and undress fully prior to being examined. This is now very rare in the UK, and more and more I find myself auscultating through clothing, for example. This is a cultural difference in the patients I believe, and what they expect will happen during a consultation.

Hippokrates Exchange Programme - Final Report

I have noticed the GP consultations are much more of a discussion between the doctor and patient. The patient often really wants to hear your opinion; after all, they have chosen to see you. As the gatekeeper to hospital care in the UK, often the patient sees me as a barrier and this affects our relationship and can make them suspicious of the advice I am giving them. This conflict of interest is not so prevalent in Austria. However, there is a tendency to over refer and over-investigate at the request of the patient, and the obvious conflict of interest in being able to bill for work done. This said, over-investigation was not as common as in other countries I have been to, mainly because every investigation will be scrutinised by the insurance companies, perhaps something less likely to be looked at in the NHS. The wonderful thing about Austria is the speed at which investigations can be obtained. My patients may wait a few months to get an MRI, for example. I am not envious of the effect of this, however: patients coming in with scans expecting me to explain them to them!

One area I would be critical of is communication skills training. For example, in one consultation I heard a verbal cue that the patient was gay. I felt this was important to discuss prior to a visit to Thailand (which he had made the year before). This raised my interest in this issue and so I asked every doctor or student I met about this. The majority felt that they were open-minded individuals, and that they would have no problem if a patient were gay. On some the idea that they needed to encourage disclosure was a new one. GPs in Austria have an especially important role to help people who may be struggling to come to terms with their sexual orientation, or more commonly have specific health promotion needs like immunisation, HIV testing etc. Growing up in a Catholic country such as Austria makes it more important doctors show they are open to discussions. I, for example, use a rainbow flag mouse-mat which on several occasions has encouraged patients to 'come out' to me. I think recording my consultations on DVD has really allowed me to analyse the cues I miss, improve my rapport with patients, and is something I would commend to any GP in Austria.

I was also impressed by the range of skills GPs use everyday in Austria, from phlebotomy, IV and IM drug administration to wound dressings. This physical contact between doctor and patient undoubtedly strengthens the relationship, and is something we are losing in the UK, in the hunt to provide the most cost effective and time efficient ways of providing healthcare.

Having spent time with the Out of Hours Doctors, I realised that palliative care could be strengthened in Austria. In the UK, a GP must make a plan, discuss resuscitation, where the patient wants to die etc. This is all recorded electronically and this plan is then visible to all doctors out of hours. So it is easier to stop fruitless treatment, manage pain, ensure an unpleasant final admission to hospital can be avoided etc.

I was impressed with the potential a school doctor programme can have to offer children an opportunity to discuss issues in their home lives, sexual development, illness self management, and also the potential for the doctor to influence, for example, the calorific soft drinks available in school vending machines. The stocking of iodine to be used in the event of a nuclear fall-out, in all schools, did amuse me though.

I would like to turn briefly to the insurance versus national healthcare system debate. Clearly the quality of care in Austria is overall very impressive, and for the majority of patients I believe they receive much more timely care than in the UK. However, I prefer the NHS system, as I believe Austria is

Hippokrates Exchange Programme - Final Report

heading for a crisis as the technology we have improves and becomes yet more expensive. Speaking to medical students, they seemed to have little understanding of health economics, and how a NHS system is better at ensuring the most important conditions get prioritised. There was also little understanding of how many conditions can truly be treated better in a community setting. An example was an uncomplicated pneumonia in a young person who perhaps does not require chest X-rays, and intravenous drugs to make an effective recovery. The idea that primary care management can be significantly more cost effective, safer for the patient, exposing to less radiation, less unnecessary infusions, less hospital acquired infections etc seemed a little novel to some. A patient seeing 5 different specialists before realising either nothing can be done, or they had the wrong working self-diagnosis entirely, is something that rarely happens in the UK due to the GP being at the start of the patient journey.

3

I was somewhat shocked to realise how little health promotion and preventative work seems to happen in Austria. It seems many things slip between the insurance and state, often due to the bizarre funding system which sometimes rewards having patients treated in hospital than them ever having the admission prevented in the first place. Exclusions from health insurance also lead to significant consequences. In England we screen young people for Chlamydia, but in Austria there is little financial incentive for this work to be paid for, as infertility treatment is seen as a condition that the individual must fund treatment for themselves.

And now I will turn to the area that seemed the most important – that of medical education. Frankly Austria has a long way to come in this regard. Before I become too critical, I saw some excellent practice. One example would be Michael Wendler who truly I hope to be able to emulate. His relationship to his trainees, both past and present, is incredible. He takes the time to get to know them and importantly, let them know who he is and what his interests are. In Britain we are often guarded in breaking down barriers between teacher and student, but Michael demonstrates very well what can be achieved if you ignore these unnecessary concerns.

Both undergraduate and postgraduate GP education could be strengthened. But two important factors need consideration.

Firstly, the culture of fear that exists in Austria. Learners seem paralysed in trying to push through improvements and being critical for fear of ramifications later on in their careers. There is a lack of meeting between the powers behind educational institutions and the learners. This culture will change I'm sure, but this change is needed to drive through any change. One change that will help is encouraging more self reflection in the learner, which would ultimately lead to the learner stating their priorities, and educational experiences being tailored accordingly.

The other is respect for General Practitioners as equals from hospital colleagues. This is a journey that is pretty much now complete in the UK. It happened through trainees rotating through lots of hospital specialties (where their contribution to a team can be immense), all students getting good exposure to general practice as an undergraduate (where they are often shocked how much we know – in the UK I do not think there is a medical school providing less than 2 months of general practice exposure), at least 50% of junior hospital doctors spending at least 4 months in General practice. These experiences help highlight how GPs deal with problems differently, and help the future surgeons really appreciate what we do.

Hippokrates Exchange Programme - Final Report

To get to this stage, however, we needed a postgraduate curriculum, and quality assurance of placements. The biggest turning point was having work place based assessments, a knowledge-based final examination and an exam of 12 simulated patients robustly marked, prior to becoming a GP. At the point of becoming a GP, I now feel confident a GP will be able to handle most things, and this confidence is being shared by many hospital colleagues too. The other big factor is insisting that any trainer of students has at least a postgraduate certificate in medical education. The other consequence of this is of course universities then having more confidence in the GPs ability to teach students. Specialists now have confidence that we can teach clinical skills and management to a high standard, and they even acknowledge that students see better patients in primary care (rather than the one patient with eczema on the ward who has already been examined by 20 students in 2 days!) The increased presence of GPs in medical school management did not happen by chance. It was the result in good quality research being carried out in general practice, also by an acknowledgment that medical curricula were becoming overcrowded and who better to manage prioritisation than a generalist, and finally by substantial investment in computers and building in the community rather than all funding being automatically handed to the hospitals.

I could go on but will stop here. I return to the UK refreshed, and excited, having made some life long friends. I sincerely hope we stay in touch, and can support each other in our own personal goals and the goals for the healthcare we provide.

Dr Rafik Taibjee July 2011
