Final Report
Hippokrates Exchange Programme

Dates Exchange: 18/7/2011 - 31/7/2011

Name of Visitor: Rachael Tait
Email of Visitor: rachaeltait@doctors.ney.uk
Country of Visitor: England
Name of Visitor's National Exchange Coordinator: Leonardo Administrator
Email of Visitor's National Exchange Coordinator: leonardoexchange@gmail.com

Name of Host:Dr Marek Oleszczyk
Email of Host: moleszczyk@wp.pl
Country of Host: Poland
Name of Host's National Exchange Coordinator: Magda Moszumanska
Email of Host's National Exchange Coordinator: szuma25@poczta.onet.pl

The fortnight I spent in Krakow within General Practice was eye opening for me. I had gone with certain pre-conceptions about what health care would be like in a former Communist Country, and I was surprised by how wrong I was.

There were a number of key areas where I considered there to be similarities and differences, and I have outlined some of these below:

1) GPs and access to Secondary Care/Specialists

In both countries, GPs are generally the first port of call for the community's health care needs. There were some notable exceptions to this though – in Poland, patients are able to access the following specialities without first seeing a GP; Gynaecology, Dermatology, Psychiatry and Obstetrics. This was interesting as I had previously consulted a number of female Polish patients in the UK with standard primary care gynaecology problems, but they had been insistent on referral to a "specialist", and I am assuming that this is a reflection of how services operate in Poland.

In general, I saw higher referral rates to specialists than I have experienced in the UK, and the Polish doctors concurred with this. They often feel "forced" to refer patients to specialists in response to their demands; apparently patients feel that GPs do not have sufficient knowledge or experience to deal with their problems. Several of my colleagues described a dire shortage of GPs in Poland approximately 10 years ago. As a result of this, there were no strict training or entry requirements to become a GP which may have resulted in a less skilled generation of GPs.

Doctors also cited a lack of access to tests and investigations as a reason for referral to specialist services. For example, GPs are unable to request

Free T3 or Free T4 blood tests, hence any patient found to have an abnormal TSH in primary care is required to be referred to a specialist.

Specialists are not based at hospitals but in offices in the community – these offices are not usually linked or near to a GP practice so patients may still have to travel a fair distance to access specialist services. Despite these specialists being more community based, GPs didn't have close relationships with their secondary care colleagues. In fact, one of their main frustrations was poor communication from specialists. GPs described frequent situations where specialists would not inform GPs of the outcome of consultations or changes to medication.

I was also told that specialists are paid on the basis of a "points" system, and a certain number of points have to be earned to receive payment from the NHS. Beyond this number of points they do not receive any extra payments. Points are earned for follow patients. Whereas in the UK, specialists are encouraged to discharge patients back to GPs as soon as is appropriate, apparently in Poland, specialists often have a large number of uncomplicated patients for follow up as it is a relatively straightforward way to maintain their income.

2) Doctors and nurses in General Practice

One of the striking differences I noticed was the roles of GPs and practice nurses. I am familiar with a system where Nurses are increasingly responsible for the bulk of chronic disease management in the community, for example, asthma and diabetes. Nurses and HCAs see their own patients in designated slots. There are opportunities for nurses to undertake further training and become Nurse Practitioners.

By contrast, practice nurses in Poland had a much more limited role. They usually also worked as the practice receptionist. They only saw patients to do blood tests or ECGs. GPs told me that nurses in Poland are generally not well respected by patients, and so patients frequently see GPs for issues that UK GPs might consider more appropriate for a practice nurse, for example, suture removal, routine BP checks and dressings.

It was not clear to me how the Polish system managed to provide enough appointments with GPs given this increased workload and an average list size of 2700 patients per doctor

3) Continued Professional Development and Professional Regulation

Again this was an area that differed greatly from the UK. There is no protected study leave for GPs, it is done on an ad hoc basis at the discretion of the practice, and does not feature in contractual regulations. There is no form of appraisal, and my colleagues were a bit bemused when I tried to explain the system and the introduction of revalidation. My Polish peers advised me that their governing body has a specified number of CPD points that each GP is supposed to collect, but that in practice this is not monitored or regulated. The onus is on the individual to inform the body of the CPD points they have collected. There did not appear to be any repercussions if the allocate number of CPD points were not attained. GP trainees are not required to pass any exams before they qualify as a GP and there is minimal ongoing assessment during training.

I was quite surprised by the lack of formal regulation. The general feeling amongst my Polish colleagues was that the system in England seemed excessive. I had previously had a similar attitude myself, but seeing the system in Poland made me value the English model more.

I firmly believe that the exchange was a very positive experience. It has encouraged me to look at alternative health care systems and what I can learn form these. I believe I have formed lasting relationships with my Polish colleagues which I hope to foster in the future. I am very much looking forward to the return exchange later this year.