**Erasmus+ funded Hippokrates Exchange Programme**

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**Participant report**

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Spending two weeks shadowing an early-career GP in an urban setting enabled me to gain unique insights and draw interesting comparisons between primary care in France and the UK. My host practice was in Saint-Cloud, an affluent town a few miles west of Paris, and consisted of six doctors, a nurse, an osteopath and two midwives. Although all work in the same surgery, they practice independently, with each doctor following their own list of patients. This brings benefits in terms of relationship-building and continuity of care, but I did miss the team-working aspects of my practice in the UK.

On entering the practice, I was struck by the lack of reception or administrative staff, who are indispensable in the UK. Instead, the doctors here have a remote secretary who they pay to book appointments for them via phone, but otherwise attend to their own admin; this extends from opening and scanning their own post to calling specialists for advice from their personal mobiles, and even receiving texts from patients requesting appointments or prescriptions. This all adds to their already significant workload and could increase the sense of operating in isolation. Nevertheless, this independence suits many doctors well and gives them a greater sense of autonomy: French GPs set their own appointment times and costs, which patients pay upfront and are then reimbursed. The state repays up to 70% of the cost with the rest covered by private insurers. My practice had chosen to charge 25 euros per 20-minute appointment, which is longer than average but allows them to spend more time with patients. However, I reflected on the potential for less patient-centred practices amongst other French GPs who are not subject to CPD and revalidation requirements, nor the standardising influence of local or national targets, guidelines and inspections.

The consultation rooms were also set up differently to any I had seen in the UK, with the doctor behind a desk facing their computer, and the patient on the other side. I wondered if this traditional layout might reflect a more traditional doctor-patient relationship, with the doctor retaining a sense of remoteness and authority. On the contrary, the GP I shadowed seemed to maintain an excellent rapport with her patients, always enquiring about their lives, jobs, and families, and her patients seemed to respond well to the transactional quality of the consultations. I reflected that meeting patients' expectations is key to a successful consultation, and when

these expectations differ in different cultures, different approaches can achieve the same results. Further, having one allocated GP seemed to enable patients to feel a stronger bond with that person, who was uniquely privy to their entire medical history, and in turn appeared to motivate doctors to safeguard the health of their patients, who they knew they could be caring for into old age.



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In fact, my presuppositions about doctor-patient roles were challenged further as I learned about the relationship between primary and secondary care in France. Again, the two appeared to operate almost entirely independently, with neither having access to the others' notes or investigations except for those which had been expressly sent. When the GP makes a referral, they write a letter to a specific specialist and give it to the patient, who organises their own appointment with the addressee. Occasionally my host felt a patient needed extra help and would call the specialist for them from her personal mobile, and was usually able to find appointment within the next week (in some cases the next day!). The practice was unusual in having a system in place to receive blood results electronically, but after undergoing imaging or specialist review the patient would return with a dossier of letters, print-outs of imaging and other investigation results. It seemed to me that this approach may risk important findings or recommendations being missed, but did involve patients to a greater degree in coordinating their own care. I felt that this provided a sense of responsibility and control for patients which can be lacking in the UK. I reflected that perhaps our own system, in which patients are referred electronically, allocated an appointment and often not directly provided with results, could in fact be more paternalistic than we realise. I came to appreciate moves towards greater involvement of patients in the UK through initiatives such as Patient Access, and wondered whether these might also see an improvement in patients taking responsibility for their own health.

I was also particularly struck by France's rigorous child screening programme, which comprises 11 individual clinical examinations from birth to age 16. My host has a special interest in paediatrics, and in two years of practising independently has accumulated a list of 300 patients, 100 of whom are children. A large part of her work therefore involves undertaking these routine examinations, which are documented in the 'Carnet de Santé' (the equivalent to our 'Red book'). While to me this regularity of screening seemed not entirely rational, given the ages and frequencies with which congenital or development conditions present, I reflected that it does serve to build a relationship between patient and doctor and reinforce the importance of safeguarding health from a young age. Indeed, France has a higher life expectancy than the UK, lower rates of obesity, and lower mortality from stroke, ischaemic heart disease and cancer (OECD/European Union, 2018). This certainly corresponded with my own experience, with most patients I saw seeming relatively well (although this is partly explained by the affluence of the area). Once again, I considered that this could also be attributed to better lifestyles, monitoring, and preventative healthcare, from which we could learn important lessons.

Many patients retain their Carnet de Santé into adulthood as it also contains their vaccination record, something which can often be unclear and inconsistent in the UK.



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I was intrigued to learn that in 2018, France made eleven vaccinations obligatory for children to enter nursery or school. Nonetheless, my host reports, there are still problems with under-vaccination as in the UK, only here in France it's believed that vaccines are linked to autoimmune conditions in later life. On investigating this further, I was surprised to read that France had the world's highest levels of vaccine scepticism according to the 2018 Wellcome Global Monitor, with a third of French subjects responding that they did not think vaccines were safe (Wellcome Trust, 2018). The results of France's new vaccination policy are encouraging however, with early data demonstrating an increase in uptake not only of mandatory immunisations but also of optional vaccines such as HPV (Levy-Bruhi et al, 2019), suggesting a general shift in attitudes. However, some fear a pushback from 'anti-vax' groups, who may try to find ways to resist the new rules. As the UK looks for ways to improve its own vaccination coverage, this highlighted for me the importance of patient involvement and education to prevent resentment and resistance against a perceived lack of autonomy. I reflected on the importance of identifying and addressing individual patients' concerns around vaccinations, and how the close relationship between GPs and their patients in France could facilitate this. I was also provoked to think more about the public health threat of vaccine hesitancy, and my own unique position – and responsibility – as a GP to explore and act on this with my patients.

Overall, my experience in Saint-Cloud provided me with a totally unique insight into primary care in a new setting, and left me keen to learn more about how healthcare is structured in other countries. It exposed me to new perspectives on the doctor-patient relationship, health promotion and prevention and patient engagement, and how these could be optimised here in the UK. I also came to appreciate certain aspects of NHS primary care more, such as the strength of the MDT and the focus on rational prescribing and screening. I felt that my placement practice represented an exemplary patient-centred way of working within a less regulated system. I left feeling energised and motivated to seek innovative solutions to universal problems, drawing on successes from other systems. I also felt better able to understand the expectations of my own patients and colleagues who may be used to different structures. I am grateful to have had this opportunity, and look forward to investigating the issues raised further and sharing my learning more widely.

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