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General Practitioners

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Participant report

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The following report does not intend to be a factually correct reflection of the Italian Community Health System but a collection of personal observations during my 2-week Erasmus+ exchange programme experience in Lecce, Italy (April 2019).

Italian GPs appeared to consistently deliver patient-centred consultations despite no clear use of recognised communication methodology. On the contrary, and due to the un-established patient's ideas, concerns and expectations (ICEs) during consultations, it was difficult for me to ascertain whether the consultation outcome was in fact in line with patients' expectations.

Consultation outcomes seemed to rely on objective findings during focused examinations. I wonder if this difference in approach (the RCGP endorses the CSA-style consultation structure which includes structured history-taking) responds to differences between the UK-trained and Italy-trained doctors or perhaps to patients' differing cultural/societal backgrounds.

One of the most pleasantly surprising differences between Lecce Community Health Service and that of the UK lies in the possibility for the "Leccese" GPs to prescribe home visits delivered by specialists - general surgery for ulcer care, geriatrics and physiotherapists being the most common ones. I was, however, informed that any specialist home visit can be requested for house bound patients. This service is centrally coordinated by a two-woman team (experienced GP and a Secretary) based in the community hospital which I visited.

Unfortunately, I did not have the opportunity to discuss cost-effectiveness aspects of this scheme but I wonder if suitable outpatient department consultations in the UK should take place in the community, at patients' homes, as opposed to being centralised at District General Hospitals which may impact negatively on patient's experience, may add to inappropriate use of ambulance services and is thought to contribute to increasing CO2 emissions as well as inner city traffic congestion due to patient's attendance to hospital appointments.

Another positive difference is that the Italian authorities seem to believe that a maximum of 1500 patient per GP is an appropriate ratio. I wonder whether concerns about patient safety are underpinning this decision. Nonetheless, these patients would normally only see their GP, rendering this relationship truly unique. As a direct consequence of this special rapport, I witnessed Italian GPs' ability to counsel their patients to buy into their chosen plan of action. At the same time, and purely from a patient perspective, I wonder if the limited variety of options offered may at times hinder





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patient's compliance and/or lead to understated patient dissatisfaction with consultation outcomes.

Unfortunately, in the UK there does not seem to be such “cap” to the number of registered patients in a given practice. I wonder if UK authorities should consider implementing such a measure based on the number of full-time equivalent GPs working at a given practice to ensure practices' responsiveness and patient safety.

Interestingly, patients in Italy seemed to be able to self-order blood tests (amongst other investigations including Computerised Tomography and Magnetic Resonance Image scans). Then patients would request GPs' interpretation of the results during routine appointments. The GP would then add the results provided onto patient's records and return the original hard copy to them. This impressed me as I viewed it as a sign of Italian patients naturally owning their health issues which in turn, I believe had a positive impact on GPs ability to hand responsibility back to them. Patients appeared to be a sufficiently efficient interface agent between GP, laboratories and secondary care specialists albeit its clear limitations such as for example cognitively handicapped patients or complex medical circumstances including co-morbidity.

However, this “self-ordering” practice, which I believe is common culture, also seemed inappropriate at times where tests had not been requested based on clinical rationale but patients' distorted health beliefs. This culture is likely to lead to direct or indirect patient harm in some instances due to unnecessary patient/relative anxiety and potential adverse effects inherent to all medical procedures.

Interestingly, I learned that there might be a minority of local health care professionals (HCP) who may favour “interventionism” over preventative medicine due to subsequent financial gain. This makes me wonder if such practice is colluding with/enhancing the “self-ordering” culture amongst Italian patients. For this reason, I am happy that in the UK, most doctors follow appropriate guidelines which support a strict clinically-based rationale to request radiological investigations, which helps avoid potential patient harm which can derived from over diagnosis.

My mentor, during this experience, completed an average of circa 20x face to face patient contacts a day with consultations being entirely patient-led (+ ad-hoc telephone consultations during 1x hour slot before morning clinic +/- home visits but strictly no appointments for children under 6 years old as a National GP policy). Most Italian GP practices run with only the support of extremely skilled receptionists since sadly, very few have their own nurses (or any other type of HCP) due to lack of governmental financial investment.

The consultation length seemed to correlate well with the number of presenting complaints or the complexity of them. More often than not, patients also consulted the GP about their relatives' health issues. In contrast, the UK primary care system, being





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rigorously time-based (with 10 or 15-minute appointments maximum for face to face consultations) is clearly not conducive to such patient-led consultation style.

I did not observe any strict rules around documenting each problem discussed (only read codes and prescribed medications are logged) during consultations which flowed from subject to subject seamlessly. This seemed to be a pivotal aspect to facilitating a genuine friendly discussion where complaint-specific health advice was intercalated with relevant public health messages. On the other hand, I believe this practice would easily render UK-based GPs vulnerable in medico-legal cases as well as in breach of their duties to the General Medical Council.

One of the main observed differences between UK and Italian medicine might be the UK's strong ethical culture where concepts such as confidentiality, consent or chaperoning are upheld virtually in every patient contact. For example, most consultations that I was present at were open-door ones. Also, discussions regarding other family members were commonly held with no explicit prior consent given or sought. Nonetheless, this did not seem to cause any apparent issues to either party. I wonder whether the UK's strict enforcement of above mentioned ethical practices in every scenario might actually be hindering timely care provision to those who may find themselves in a vulnerable position (i.e. full-time workers, geographically isolated or house-bound individuals, individuals with significant cognitive impairment/learning disabilities).

Personally, the most impactful learning experience has been to witness the many benefits (as well as the often-neglected potential) of unrushed consultations. Sadly, in UK surgeries the number of patients seen appear to trump the quality of the consultations and productivity appears to be measured by quantity rather than quality. It is my firm belief that time-pressures placed upon all consultations does not allow for quality headspace to discuss relevant and complex issues which in turn may limit the quality of the output which ultimately affects patient care.

It is clear to me now that time is of the outmost importance to establish not only rapport but also trust and a healing relationship. Time-based appointments are not fit for purpose, especially for long term conditions / elderly / medically complex / learning disabilities / mental health where a "multiple-10-minute consultation" strategy might simply not be satisfactory or safe.

To continue with this approach risks to completely lose the already damaged aspect of "continuity of care", much valued by most patients, as a direct consequence of increasing pressures placed upon UK GPs.

Following completion of this period of observation, and despite the above noted critical reflections on the NHS, I have returned to the UK feeling more appreciative of the organisational aspects of our "imperfect" primary care system as well as the





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exceptional value that our allied HCP such as practice nurses, physiotherapists, paramedics and HCAs add to UK practices.



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