



Royal College of
General Practitioners

Erasmus+ funded Hippocrates Exchange Programme

Project no.: 2018-1-UK01-KA102-047158

Participant report

Dr Lindsey Kent

ERASMUS PROGRAMME REPORT :

Reflections from a period spend at USF Da Baixa in Central Lisbon.

USF Da Baxia: 10 doctors, 9 family nurses, 5 administrators, 7 trainees, 1500 patients per doctor

Learning Outcome 1: Primary Care Management

1. Primary care – Organisation of primary care – article and from discussion / observation

Article: Biscaia AR, Heleno LC. Primary Health Care Reform in Portugal: Portuguese, modern and innovative. *Ciencia & Saude Coletiva*. 2017 Mar;22(3):701-712. DOI: 10.1590/1413-81232017223.33152016.

Family Health Unites (USF “Unidades de Saúde Familiar”) were established after a reform of primary care in 2005. These health centres were designed to respond in an autonomous way to the health needs of their populations and represented a change from the hierarchical organisation of public services in the past. Health Centre Clusters (ACeS – “Agrupamentos de Centros de Saúde”), like CCGs in the UK, were also established. An emphasis was placed on improving governance and accountability. Drivers for this change included a desire for staff and patients to derive greater satisfaction from the Portuguese NHS, reduce regional inequalities, and to introduce quality and technological reforms that would bring the system more up to date.

Interestingly, the model used for this was the UK’s primary care system, with its emphasis on QOF targets to improve care quality and the CCG model as mentioned above.

Another important influence of chance was the Portuguese Blue Book, “A Future for Family Medicine in Portugal” which was a primary care manifesto written in the 1990s by the Portuguese Association of General Practice/Family Medicine. This proposed detailed plans which were ready to be implemented in just 6 months.

The USF model consists of a primary care centre, staffed by multidisciplinary teams. In practice, this means family medicine nurse, social workers and clinical secretaries as well as GPs. There is hope that this will extend in scope (in line with the development of additional roles in GP practices in the UK) and USF da Baixa employed a social worker with an interest in developing their social prescribing service. One benefit is the ability to staff their centre





based on the population they serve and that they can be self organised and are able to respond flexibly to the population's needs. The internal structure (as I witnessed during meetings) includes a centre coordinator (elected), as well as a technical council (who implement clinical governance and who are also elected) and a general council (includes all professionals and they will vote EQUALLY on decisions about their function/roles) They aim to meet objectives of the centre, laid out in an action plan and achieve goals relating to care quality and health outcomes, which has been outlined in a letter of commitment.

Primary care practices are open from 8 a.m. to 8 p.m. Monday to Friday. The after-hours service is practice-based. GPs within one practice or organized in a group of practices look after their patients on out-of-hours schedules. The scheme of after-hours primary care is uniform all over the country. The only difference between regions is the opening hours, depending on the distance to the nearest emergency hospital department. When the hospital is nearby, after-hours primary care is opened only for the evening; when the hospital is distant, after-hours primary care services are available all night. GPs in family health units are being paid for each home visit to a maximum of 20 visits per month

Observations:

- a. USF – family health centre – funded under NHS
- b. Patients make co-payments (Patients with a low economic status, children, pregnant women, family planning related visits, chronic patients, blood donors and firemen are exempted from any co-payments.)
- c. Small section of patients have private insurance – not replacing NHS, but supplementing it (ie skip queues, access choice of specialist etc)
- d. Funding very centralised, now in post austerity period
- e. Shortage of space to deliver health care (hospitals and GP)
- f. Shortage of GP staff
- g. Mental health – limited services, psych care is via referral, GPs often prescribe the meds to patients who have not had a recent review, legally limited use of laws to section. Homelessness and mental health issues are very complex to manage.
- h. Child services are good – there is significant investment in early years care which is led by nurses and doctors together with more numerous reviews by a doctor in the first two years of life compared to the UK. This can build good relationships with families, continuity is maintained, early identification of problems occurs, reassurance and childcare advice for isolated populations.





- i. QOL in older people over 65+ - no specific measures, this practice has some social prescribing with accessible opportunities for older people
- j. Multimorbid patients are managed in house with some specialist clinics ie for diabetes. Many patients are complex and have issues around accessing health-care so management is opportunistic and proactive with screening even young patients with risky backgrounds. Lots of chronic disease management is in house in primary care, with the complex only referred into secondary care.

LO2: Community Orientation. Focus on collaboration/Health care delivery

- k. AHPs and community services – no direct access to pharmacists, physios, OTs, PAs. No real mental health care in the community. No community rehabilitation services or intermediate care. Difficult to arrange care to be delivered at home in a holistic way, may only do medication prompting or make food etc but not personal care.
- l. GPs act as gatekeepers to secondary care, much like in the UK. Referrals are done via letter but also into an electronic system, records of referrals are added to the EPR. Referral information can be viewed to see the number of days wait for a speciality – this is higher in specialities such as dermatology and ophthalmology where even though doctors are trained by the NHS, they can go almost immediately into the private sector. Waits for specialist paediatric ophthalmology, for example, can be almost 1 year. All scans and bloods are also ordered – with patients taking paperwork with requests on and then collecting results to bring back to GP.
- m. Cost savings – difficult, reported to be hard to collect data on reduced admissions. Anticipatory care planning is prioritised and aim is to reduce use of urgent care services. Governmental aim is to reduce access to A&E, possibly in future by cutting fees needed to pay to see GP and review out of hours provision. Long term aim.
- n. Future funding aims – interest within this practice of having more devolved/regional funding access and ability to recruit staff and spend on services which would be of direct benefit to the community i.e. translators. This is likely again to be a long-term aim.

LO3, 4, 5: Problem Solving, Comprehensive Approach, Person centred care and Consultation

In Portugal, GPs have a longer consultation period of 20 minutes. The style of consulting is very similar to UK models. History taking involves exploration of a presenting complaint, a review of past relevant history and medications and there is also use of an 'ideas, concerns, expectations' type model and a holistic approach is practiced. Very good understanding of psychosocial aspects and on determinants of health. One element of history commonly taken here is about the person's educational level and their job histories which is sometimes less emphasised in the





UK during consultations. There is also more curiosity about the person's journey to Lisbon and about other countries and cultures they have spent time in, as well as their preferred language. It was very important to have this information to help tailor consultation, provide appropriate information and promote access to best resources.

- o. Emphasis on whole person understanding is a key part of the interaction and this is important in order to better look at social determinants of health. This really affects how problem solving around management and follow up might work.

Rehabilitation/Palliation/Health Promotion/Preventative care

- p. Rehabilitation centres do exist and patients can be referred for this care.
- q. Palliative care beds and centres do exist – but palliative care not carried out much by GPs, and they are not encouraged to use anything like GSF or do advance care planning or DNACPRs. Often done by hospital doctors. Many patients die in hospital. GPs not comfortable with discussion and patients often not clear on prognostic info from specialists. Forms which are completed for advance directives/CPR decisions have to go and be notarised and are uploaded in a delayed way to EPR. Do sometimes have to explain terminal diagnoses to patients sent out of hospital.

This article summarises palliative care services in Portugal: Palliative care and the Portuguese health system, Marisa Braga da Cruz and Rui Nunes Porto Biomedical Journal. 1(2):72–76, MAY-JUNE 2016 DOI: 10.1016/j.pbj.2015.07.002

“Palliative Care Unit (PCU) – provides in-patient care, therefore, it is a service specifically designed to treat and take care of palliative patients. The unit can be in a hospital for acute or non-acute care, a ward, or a structure adjacent to the hospital, it can also be completely independent of the hospital's structure. It should always work with an early discharge perspective and transfer to another type of care, unless it is a dedicated “hospice” unit, where patients remain if they want and need, to die.

Hospital Support Palliative Care Team (HSPCT) – provides palliative care advice and support to the entire hospital structure, including patients, family and caregivers in the hospital environment. It also offers formal and informal training and interconnects with other services inside and outside of the hospital.

Home Palliative Care Teams – provide care to patients in their home, as well as support to their families and caregivers. Furthermore, they offer advice to family doctors and nurses who provide care at home”





Royal College of
General Practitioners

- r. Health promotion – emphasised very much during consultations. Not often offered smoking cessation but support is available. Alcohol services are separate within the health service and not much link in with GP. Safe alcohol levels not always emphasised. Fewer guidelines on this exist. Lots of best health promotion work occurs with regular contact with the nursing teams. Dietary advice given to patients at high risk or struggling economically, with good early referral to food banks or other third sector supports.
- s. Preventative care – this is often done as part of early years care for children. Regular contact with nursing teams allows advice to be given about promoting health and interaction, basic parenting etc. Community and social prescribing initiatives exist to help support the vulnerable.

Dr – Patient relationship / Interaction / Dynamics

- t. Doctors are very highly regarded in Portugal and doctors are referred to respectfully by patients. I liked that in Portugal all staff are dressed more casually and lots of informal speech was heard during consultations. I found it interesting that very often women were comfortable with having intimate examinations performed by male doctors – this is culturally accepted. Less emphasis is placed on putting patients behind a curtain to get changed or using a sheet to cover. Consultation model – noted elements of Neighbour's 1987 model (This uses the five checkpoints of connecting, summarising, handing over, safety netting and housekeeping alongside an awareness of 'minimal cues' (verbal and non-verbal) to help discover the unspoken agenda. The closeness and respect that existed between doctor and patient was clear – I loved how sharing food from home like an amazing chicken biriani was part of developing that relationship.

Holistic Care

- u. Each interaction seemed focused on understanding a person's context. A background history was always very thorough and questions about their community and culture were included in history taking in USF Da Baixa. This aided shared decision making, and social and cultural factors were often addressed as part of healthcare. On a number of occasions people discussed their health beliefs and treatments and explanations were geared towards helping patients understand how these might fit in with more traditional medical approaches. Social prescribing is really beginning to gather momentum and this is very much led by the doctor I shadowed and his team. Links with community groups are strong and a recognition of the need to consider whole person care informs their approach.

LO 6 Austerity



vasco da gama movement



Erasmus+

This project is funded
by the European Union.



- v. Unfortunately, less able to cover this due to the pandemic. Aim is to instead complete a joint piece of work looking at the pandemic response in the UK versus Portugal. Ongoing work on this at present – aim is to present at WONCA
- w.

Lessons to share:

1. Continuity – true continuity with individual doctor patient lists, usually of entire families. Families from Bangladesh are well known. Usually a man presents first for care, obtains residency, brings wife, pregnancy is usually very fast and then the baby is also under their care. People have a real affinity and respect for their primary care physicians and that closeness makes care giving easier and really positive.
2. USFs are key hubs for helping patients coordinate all their care – in any initial assessment appointment, doctors spend time really investigating what has happened, when and use multiple sources of information to do so. Can be rewarding but also at times frustrating. Can manage complexity and follow up and be trusted source of support for patients.
3. Build trust with local communities – patients may come to see their family doctor first before anyone else and have faith in disclosing sensitive information and having examinations.
4. Social prescribing – the team clearly recognised innovation needed to meet needs of community. Links to projects such as memory café, ‘mentors for migrants’, 3rd sector and religious groups, Walk With A Doc
5. Young, dynamic practice – leading service in challenging area. Patients from 94 different countries, spanning full age range, lots of patients from low SES but also higher SES as areas change/are gentrified. All use health care differently.
6. Social determinants recognised as being more important to address than simply diseases themselves. Awareness of limitations of what health care system can offer at times and keenness to look at wellbeing differently
7. Access to psychologist and social worker in house. Also great that all pregnancies are followed up in house.
8. Resources in multiple languages in written and spoken form readily available
9. Jobs for primary care doctors are jobs for life within the NHS – though they may not get the most favourable T&Cs. Contracted for 40 hours.

Areas of difference:





1. Lack of skilled AHPs to carry out duties that may free up doctors such as smears, baby checks etc (though they do excellent wound care, family planning work (though not practical parts and other roles well) Some work on exploring barriers to extended roles for nursing staff has been undertaken so there may be some shift on this in future.
2. No regular use of Language Line or translating services (often not medically trained translators and there is a feeling that the service not very accurate and don't always have person available in language needed)
3. Not always able to arrange separate consultations with women from muslim communities without husband present or translation. Unsure if missed opportunities to screen for domestic violence or mental health issues.
4. Not routinely offering chaperones to people for intimate exams and not all rooms have dividers. They are offered support such as piece of examination paper roll to cover selves. However, this seems to be widely culturally accepted.
5. Reduced number of guidelines and variability in practice. Portugal may have developed guidelines with the priority of improving economic performance in mind, not necessarily with a view to targetting areas of most pressing clinical need. They are not updated regularly. Physicians often use Dynamed etc to keep abreast of new developments and modify management which is really useful.
6. GP trainees do not have regular assessment or review but instead are dependent on submitting evidence of success in training over 4 years in one final folio and presentation. More pressurised, and more vulnerable if not supported. Have to do research component.

Cases:

NB patient identifiers have been removed and some aspects of histories altered to protect confidentiality.

1. Pneumonia of uncertain cause – possible Covid19

36 M from Bangladesh, resident in Lisbon for 4 years and a restaurant worker presented with a 5 day history of cough, shortness of breath, fever, reduced appetite and muscle aches. He had felt unable to work for 7 days and symptoms had worsened three days ago. He had no recent travel history to any countries identified as being risky during this early part of the pandemic, or contact with anyone with symptoms or who had travelled. He was taking paracetamol for pain and fever which was helping.

Prior to this consultation the patient had been asked to wear a mask due to his symptoms.





Royal College of
General Practitioners

On examination he was evidently tired and more SOB on walking short distances. RR was normal at rest, sats were 98% and he was not pyrexial (but had taken paracetamol) He had crackles in his right middle zone, was quiet at both bases and was holding his right side on deep breathing due to pleuritic pain.

He was sent for a CXR which showed: left middle zone consolidation, opacification at left base, fluid in the horizontal fissure, with some right hilar shadowing but no dense consolidation on the right side. His bloods were unremarkable, with no lymphopenia or raised WCC.

The GP commenced treatment for community acquired pneumonia (amoxicillin) and he was safety netted. Repeat bloods were ordered for Friday with the nursing team.

He re-presented on Thursday feeling worse with more SOB on walking, ongoing fevers of 39 degrees at home and feeling very tired. He was sent to hospital (but did not yet trigger public health criteria for swabbing and sending to the nearest hospital managing COVID patients) They repeated a CXR which now showed bilateral consolidation, ground glass changes bilaterally and more fluid in the horizontal fissure. He was sent for a CT which showed ground glass changes, consolidation (more in the lung areas next to the pleura) and bilateral multi lobe consolidation. He was tested x 3 for Covid (negative each time) but was also negative for flu, RSV, pneumococcal and legionella antigens. He remains in hospital on treatment.

We noted that this patient regularly attended a densely packed local mosque and there were reports that others in his community had been told to attend for prayer. This was felt to be acceptable in terms of transmission risk as attendees would wash pre-prayer (however not with soap so this would be unlikely to remove the virus) We were able to pass a message to the imam to advise people to pray at home if febrile, with cough or SOB or if they had any significant travel history or contact with anyone positive for coronavirus.

As a result of this consultation both myself and my lead clinician were asked to self-isolate to protect staff and patients until the coronavirus results were obtained.

In the days since, cases have more than doubled with rising numbers in Lisbon and 69 patients requiring admission in the country. Numbers will continue to rise.

2. A Multi-National Health Care Journey

A 62 year old female patient presented for a new patient appointment. She had been living for the last 15 years in San Francisco, working as a nanny for the children of a family there. Fortunately they had paid for excellent health insurance as two years ago she saw her doctor because of significant weight loss. Despite attributing this to her busy life and work, once she developed persistent diarrhoea she understood it





Royal College of
General Practitioners

was time to seek help. She was diagnosed with sigmoid colon cancer and operated on within days, undergoing a year of chemotherapy after this. Following her initial surgery she developed a surgical site hernia which required more surgery to repair. She was found on her repeated scans to have both a lung and thyroid nodule which required follow up. She also developed a left introductory papilloma of her breast and was commenced on anastrozole. Since completing her chemotherapy she unfortunately had no resolution of her drug induced peripheral neuropathy and struggles with persistent lack of feeling from her midfoot to toes. She also developed symptoms of anxiety and depression (and perhaps an element of PTSD) and missed her family and friends in Portugal. She decided to return and begin navigating the changed health system here, but had a good network of support having previously worked in a radiology department at a local hospital. She was hoping that her treatment could be continued there, which could certainly be supported by the way the system in Portugal is organised. She was also an extremely confident patient in terms of taking ownership of her own care as under the US system she was required to take her lab work, scan results and images and summaries of care between doctors. She had a well crafted narrative of her symptoms, diagnoses, other medical issues and was very well versed in drug treatments and future planned monitoring. This is something that happens much less in the UK, though there have been articles in the past which have suggested safest care is provided where patients are able to repeat and summarise their own histories, to each doctor they see in hospital. 'Have your health story ready' is something patients are told in the USA and it was evident here. I wonder if there are advantages and disadvantages to this approach – certainly it was refreshing to have such a confident patient, expert in her own care. It helped to establish an effective 'team' relationship and did save time. She was able to advocate effectively and make suggestions, using the language of specialist medicine comfortably. She took ownership of her health and healthcare and was invested in future treatments. However, this could feel at times like a potential burden for the patient – to have to recount this information repeatedly, to have to explain specialist medicine to medics in other specialities, to continually have to travel with scans and results which may be reminders of a more difficult time. There will be patients for whom this 'work' or job of being a patient may be too much – there may be barriers to them being able to take on this role due to physical or mental disability. It may have an impact on mental health. For me, it was a privilege to view a number of different medical worlds through the lens of this person's experience and to see how beautifully her primary care physician in Portugal understood her current needs and concerns – she felt like she had come home, and she had found a home with someone who would help her to navigate her care in USF da Baixa.

