The Erasmus plus exchange was a very interesting experience for me. I have always been keen on participating in an exchange in Europe and this opportunity provided an ideal way of gaining insight into how general practice is carried out in other countries as well as a means of exposing myself to a different culture.

The learning objectives I set out at the start of the project were helpful because they provided a focus for me to explore certain aspects of the health care system during the observed consultations.

1-In Spain, there is no one national resource for evidence-based practice. Instead, there are numerous tiers of resources to which family medicine doctors can reference. These include the national ‘DIANA salud’ which is a Cochrane website, the regional ‘3 Clics’ website that provides evidence-based medicine for Cataluña and finally, the local intranet for Cat Salud. This last resource is updated by the centre’s professionals and thus is not the most up to date source of information.

I think that in the UK, we are lucky to have NICE. It is one specific resource, which we can trust and which is evidence-based. If our clinical practice is based on this then we can be sure to be practicing safely. However, I do not think that there is a particular hindrance in Spain without a NICE equivalent. It seems to me that the doctors might be more up to date with changes in clinical practice if they have to use multiple resources of clinical evidence since NICE does seem to lag behind at times whilst guidelines are being updated to incorporated the ever changing advances in medicine.

2-Antibiotic resistance is a big concern worldwide. It is said that superbugs will make simple operations in the future almost impossible because of limited availability of suitable antibiotic cover post-operatively. We have strict rules in the UK about prescribing antibiotics and there is a limit on what is available over the counter. Most conditions require a review from a health professional and a prescription, which follows the local antibiotic formularies. If a doctor prescribes outside of this, a justification is generally documented.

In Spain, there is a national antibiotic formulary called ‘Guía Terapéutica en Atención Primaria’. This book is the guide for GPs with regards to the management of a lot of conditions. It is a very easy book to follow, which gives a summary of the clinical condition, the non-pharmacological and the pharmacological options for treatment. Dra Pedro informed me that there still remains a problem with some pharmacists
issuing antibiotics to patients and then the patients attending the GP for a retrospective prescription to take back to the pharmacist. The doctor is not obliged to do this but they tend to issue the prescription the first time. However, on the whole, patients need to have a prescription before pharmacists will issue any antibiotics. This provides an essential barrier against the unnecessary use of antibiotics and aids the fight against drug resistance.

3-There is always a struggle to fairly distribute limited resources in a free healthcare system. In Spain, the waiting times for secondary care referrals seem to be similar to the UK. Some services are quicker than others and the areas with long delays appear to be comparable such as dermatology and ophthalmology. Some patients opt to have private health insurance to speed up the process and this is similar to the UK. Patients seemed keen to be referred quickly to secondary care for their medical conditions and Dra Pedro informed me that it is a constant battle trying to act as the gatekeeper and educate the patients that not everything needs a hospital doctor to be managed correctly. I felt that in the UK, the GP is more established as a gatekeeper and patients are more accepting that a specialist referral will be made only when the GP has exhausted all options for management in primary care. In Spain, consultations are also 10 minutes and the GP tends to do their own referrals whilst the patient is there. The clinics are 6 hours with a 30 minute break in between. Home visits for chronic patients are scheduled in for one day of the week and the nurse attached to the doctor also attends. There are 2 nurses per doctor and this is useful during on-calls since they do a preliminary consultation for the doctor. Acute visits and telephone calls are scheduled in at the end of the clinical session.

4-I really enjoyed observing consultations in Catalan and Castellano. It was interesting to see the patients and Dra Pedro switch between the two languages seamlessly depending on which language allowed them to better express themselves. She was also keen to consult in English when the opportunity arose. It highlighted how being fluent in multiple languages gives a doctor an extra tool to work with during a consultation. It can help relax a patient and increase the trust between the two parties. Having just done my CSA, I wanted to see if there was as much of a push to use specific consultation models during consultations, as we are encouraged to do. I learnt that this was not the case in Spain. I did not think it affected the rapport with her patients and fundamentally I feel that if you give your patients time to speak, listen and respond to their cues, a consultation will be successful regardless of what model you have used.

5-In Cat Salud, there is a social worker Giles who manages all the social care issues. She is located in the same building and is easily accessible to discuss cases. Her role is very important and busy. Waiting times are 2 weeks and she arranges assessments at home. She is responsible for doing OT assessments, arranging care packages, falls alarms and respite placements for up to 1 month. If patients have money, they have to pay for their care package.

6-I also spoke to David, the trainee who is attached to Dra Pedro, to find out how their training differs to ours. In Spain, they have 4 years of training. This includes a short
session in a GP setting in their 1st year and then their 3rd year. In the 3rd year, the trainees have to do on calls in GP weekly whilst doing their hospital jobs. The final year is completely in the GP setting and trainees carry out clinics with their tutors.

As a trainee on a 3-year course, I do not know if it is better to do an extra year. However, I believe that more time a doctor has supervised can only be a positive thing. In Cat Salud, the GPs have daily training for 1 hour. It consists of a topic delivered by a hospital consultant or a GP on behalf of the specialist. There are also weekly MDTs with a psychiatrist and a psychologist to discuss any difficult patients. This level of continued group learning is something I was very impressed with. It is hard to find time for personal development in a busy GP life. The fact that Cat Salud schedules in paid learning sessions is commendable and something practices in the UK should consider doing more often.

Overall, this was an excellent experience which highlighted how much I enjoy immersing myself into a different culture and exploring any differences which can improve the way GP is practiced in the UK. I would highly recommend this exchange to another doctor.