What a wonderful experience! It was an excruciatingly hot August when I was attending the two GP practices in Palermo to which I had been assigned, one in a richer area and one less salubrious. The fact that I had arrived in the middle of a national holiday immediately led to me to discover a big cultural difference! Sicilians take their festive time seriously and those who can leave their oppressively hot cities during ‘ferragosto’, do. This means that the intensity of the GPs workload is greatly diminished during August and so I have to stress that I was told that my experience was in no way representative of their work for the rest of the year. My hosts were extremely welcoming and keen for discussion, comparison and clarification of any points either clinical or organisational. My limited level of Italian (intermediate) did at times impinge on my ability to understand exactly how systems worked and the social, psychological and cultural nuances of consultations but overall I could understand enough to achieve my learning objectives and to find the experience fascinating.

In Sicily GP practices are generally staffed by one GP and their secretary, although in the north, I was informed, the multidisciplinary health centre model to which we are accustomed in the UK is more commonly found. The maximum number of patients that an Italian GP can have on their personal list is 1500, compared to the average of 2200 in the UK, and their budget is assigned per capita with premiums for patients below 16 and over 65 years. When they first open their practice they have to accrue patients, either by developing a reputation, buying them, taking over their care or inheriting them from a retiring doctor.

The most striking part of the experience for me was how deeply I was moved by the relationship between Sicilian GPs and their patients. It seemed to be much closer and affectionate than that which I have seen in England. From what I observed in the practice of two different GPs, patients frequently affectionately hugged and kissed their GPs and enquired about their wider families, something which I found most heart-warming. I commented on this tangible closeness to one of my supervisors and he replied 'This is what it is to be a family doctor, knowing all the generations and living affectionately and effectively with them all'. Because of their rigid lists and clear continuity of care their relationships are developed over many years and have a real depth of feeling that I think our flexible lists in the UK preclude. Sicilian patients seem to really value the continuity of seeing their own GP, something which I think patients, especially the younger generation, have forgotten the value of as they see a different GP on every visit in the UK. The continuity of care that I witnessed meant that I very rarely saw a GP refer to their computer notes and they seemed to know their patients’ past medical, family and social histories extremely well as they are often the GP for the extended family. I saw that they were able to spot clinical signs of disease in their patients that the patient themself might not otherwise have noticed and they were able to address these sensitively and appropriately with the patient due to their longstanding relationships (e.g. a heavy
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smoker who the GP noted had clearly lost a lot of weight and suspected might have a lung malignancy whilst the patient had not noticed anything). I came away from the experience hoping to be able to find a practice in the UK that still maintains personal lists and I now feel the need to encourage patients to see their own GP rather than just whoever happens to be available at the convenient time. The differences between the Italian and British appointment systems make this much easier in Italy. They seem to have a very flexible system when it comes to appointments. GPs run a clinic for around 4 hours a day and they finish whenever they have seen everyone who arrived during the clinic hours. People call on the day to arrange approximate times but you can also just arrive and wait your turn to be seen as long as you arrive within the stated clinic hours. When there is less demand the doctors spend longer holistically exploring their patient’s problem and when the demand is higher they are much more concise. For example, because of the fact that it was mid-summer and demand was lower, the GPs I shadowed were spending up to 45 minutes with patients and explained that they really valued the opportunity to give their patients more time. It seems inconceivable to me that the British would tolerate the waiting times that might be possible in this system but yet the lack of timed appointments also means that if you want to see your doctor that day then you can if you are happy to wait, unlike the 8am mad rush for the limited number of appointments that occurs in the UK!

An organisational difference that I observed, for which I can see both positive and negative aspects, is the fact that there is far less paperwork for the doctors to wade through. If they feel that a patient needs blood tests, imaging or a referral they write a prescription for these and then the onus is on the patient to handle the logistics and return with the results for discussion. If the patient does not come back with the results of investigations then the GP will never see them and they won’t necessarily be worrying about them in the meantime! In Sicily the obligation seemed to be very much on the patient to be the point of coordination between primary and secondary care which gives them a much greater degree of autonomy and awareness of how and when their care is carried out whereas in England this role falls more to the GP. The patients in Sicily bring medical folders to their appointments that contain all the results of their investigations and specialist letters which the GP will only see if the patient brings them to their attention. My host GP lamented the fact that often the responses from specialists did not address her concerns as the system of referral is not so formalised as in the UK, and often just involves a very brief prescription note to see a specialist with little history. Hence the specialists address the patient’s concerns, rather than that which the GP had hoped they would address. The fact that the patients hold all their information and bring it to the GP means that the GPs don’t have reams and reams of blood test results, imaging reports and specialist letters to wade through after clinic hours. Although from a GP’s point of view this could be seen as less than ideal as they might not have all the information that they need to bring the clinical picture together, it does mean that the patients and their families seem to have a greater understanding of their conditions and management as they are so actively involved in organising and coordinating their own care. The GPs that I met in Sicily seemed far less stressed and over-burdened than any I have encountered in the UK and I think this may partially be due to the differences in the logistical organisation of their health service. We are drowning in proformas and guidelines in the UK that seemed to be largely absent from Sicilian practice. I also found myself wondering if the fact that patients have to organise their own
appointments and investigations rather than receiving an appointment time in the post means that there are less missed appointments or DNAs in their system.

One thing that really took me by surprise is that patient confidentiality did not seem to be a concept that was considered of great importance in Sicilian practice compared to the sacrosanct nature with which it is treated in the UK. Sicilian GPs are accustomed to interrupting consultations by constantly answering the phone to other patients and discussing their medical concerns in front of others whilst the receptionists walk freely in and out of the room during consultations to raise other patients’ issues. This didn’t seem to bother patients in the slightest but it was such a stark contrast to our rigorous obsession with patient confidentiality in the UK. For my part I found the constant interruptions incredibly distracting to the flow of consultations. I asked one of my supervisors about this and he acknowledged the chaos, saying that his patients were much like his family. ‘You wouldn’t keep a member of your family waiting if they wanted to ask you something so you deal with issues as they arise’. This is definitely a cultural difference as we wouldn’t expect an immediate response but nor would we tolerate our GP being interrupted in mid-consultation without permission.

The national health system in Italy requires that patients partially pay for their investigations or specialist appointments unless they have exemption due to low income, disability, chronic conditions or cancer etc. They pay for the ‘ticket’ for bloods, imaging or referrals, which is around 30 euros. I feel this partial payment means that the patients are investing in their care and so have more active involvement in solving their own problems rather than handing them over to the GP and expecting them to provide the answer. Coming from the UK where there is no payment for any NHS service I have always been fiercely against payment but now I can see that there may be benefits to patients as well as the health service overall - although I still hold concerns about equality of access to services once payment is involved.

One area in which I came away really appreciating the positives of British practice is in our training. On discussion with some GP trainees at a social evening I was shocked by how their training is only observational. They sit in with a GP, much as we do as medical students, and discuss cases but they never see their own patients in a supervised environment. The first time they do is when they have completed their specialist training or in the occasional periods when they step in, unsupervised, to deputize for a GP that is on holiday. It can often be 12 years to find a GP post after completion of training in which time people often work in urgent care, public health, auditing for the health authority or vaccination programs.

I now more fully appreciate the multi-disciplinary and team-working environments that we have in England, having seen how isolating being a solo GP could be and how quickly your practice could diverge from that of others without in-practice education/local training sessions. Having colleagues working alongside you means that you can easily ask for their ideas and input in any given case and use each other’s specialist areas of knowledge, which can be very enlightening/reassuring. I also really appreciate how little we see of drug company representatives in England and how decisions regarding the formulary are made using evidence based medicine.
at the CCG level. GPs in Sicily tend to see 2 or 3 drug reps a day which I found shocking, to the extent that I found myself wondering if it would be possible to remain detached and critical of the evidence they present to you on a personal basis.

Overall the exchange was invaluable experience; to see, if only for a very short period, the way in which my specialty is conducted in another country highlighted areas of my practice in the UK that I took for granted or that I had assumed were the only way to do things based on my previously limited experience. It particularly reinforced the benefit of international cooperation and sharing of experience and gave me a desire to continue working internationally through research and attending conferences. The key experiences that I will take away from my transnational mobility will be having seen the benefit of true continuity of care in general practice over several generations of a family, appreciation of the quality and style of GP training in the UK and lastly the importance and utility of 'shared care' and shared-responsibility in general practice both for patients and GP wellbeing.