The exchange programme
I can't quite believe that this experience is not well advertised. I would highly recommend it to other GP's (general practitioner) and GP trainees. I heard through word of mouth from other GP trainees about the ERASMUS exchange and this has been one of the best experiences of my life. On reflection, this experience in Lisbon will influence my future practice and has reminded me of the enthusiasm and inspiration of being a GP once again.
A realisation that GP's everywhere are working towards the same goal. Striving for the best patient care possible. Paying careful details to public health, educating patients and taking a patient centred approach to care.

The setting
My exchange GP host was based in the USF da Baixa, Lisbon, Portugal. The host practice was based in Central Lisbon. This was a modern practice built 1 year ago with 9 young doctors all working 5 days a week. I had the opportunity to observe general practice consultations with doctors and nurses. I also went on home visits with the nurses.

Interesting encounters and my reflections
Not being able to speak Portuguese I thought I may struggle for two weeks observing consultations. This was not a problem, around 50% of the consultations I observed with the GP were in English. This is largely due to the diverse population in Lisbon. Including an increase in the migrant population in Lisbon. I noted particularly patient’s who have migrated from Nepal, Bangladesh, Pakistan speak better English than Portuguese. Many did not speak any Portuguese. This was a big challenge for the host GP with no immediate access to telephone interpreters. The host GP was faced with the situation, to do the best they could do with family members and friends to translate. The host GP had an interest in migrant health needs, inequalities in health care and social prescribing. The host GP was proactive in promoting migrant health and ensuring their needs were met. He would encourage migrants to take free Portuguese classes that would help them living in Lisbon. This is something I had not thought to do before in my practice. We rely heavily on interpreter services. In future, I would also encourage my patients to consider learning English and signpost them to services that can help with this.

I had the opportunity to participate in a workshop focusing on tackling health inequalities in migrant populations at the Host GP practice. This allowed me to see the wider picture and some of the barriers faced by the Lisbon Population. Subsequent to this, I have now teamed up with my host GPs and UK GP’s involved in previous GP exchanges. We hope to deliver a similar workshop at an academic primary care conference later this year. We have summited an abstract for this. This strengthens international ties and collaborative work developed during the exchange.
I would like to pay attention to the host GPs efforts to participate in driving forward with social prescribing. One evening, I joined my host GP on a ‘walk with a doc’ project he has set up in Lisbon. Initially this project was set up by a doctor in the USA and has started to span the globe.

Around 20 patients joined in the 4 km walk. Prior to the walk he offered a 30-minute session on flu/viral infections and how to self-manage and when they should see the family doctor. After running this scheme for 3 months the host GP has proposed the idea to his local CCG to set it up in other parts of Lisbon and to help him develop more projects involving social prescribing to help patients.

The majority of my time was spent in a central Lisbon GP practice with my host GP. My host kindly organised for me to spend half a day at another GP practice in Barreiro a different town across the river Tagus. This was different patient population and I got to see a variation in how practices run in Lisbon. Furthermore, I had the opportunity to visit a community drug clinic which is run by infectious disease doctors and nurses. This service provides a place for people to drop in for a warm drink, something to eat. The service also offers a rapid screening service including HIV, hepatitis B and C and syphilis. There is access to consultations with a nurse and doctor and social worker. There were peer support workers available on hand. They also have access equipment to minimise harm to people such as smoking and injecting equipment, condoms. There were also clothes, hygiene, cosmetic products and access to telephone and internet services. The entire service is free and anonymised service for the general population.

A few reflections on the role of the family doctor in Portugal and comparison with the UK

GP's, or family doctors as the Portuguese would call play a key part and integral patients care. GP's have their own patient lists up to 1,900 patients each. The Portuguese GP’s put an emphasis on continuity of care. Patients would see the same GP each time and this is something becoming less common in London general practice. Interestingly in Lisbon, patients do not choose their GP’s. Patients are assigned to a GP and they should see the same GP each time unless it is an acute problem and their own GP does not have any appointments. There is an option to change GP, but this is not encouraged or advised. This means GP’s in Portugal are very available for their patients with most them working 5 days a week. Most full time GP’s in London work 4 days and many GP’s are part time. This is good for continuity of care for patients but, I am not sure GP’s in the UK would want to be bound to working 5 days a week as many have settled with other roles.

The host GP had 20-minute appointments, but a lot of the time gets consumed in typing out patients test results individually during the appointment. This was frustrating for the host GP as they get less time to speak to the patients which they would prefer. In London, we are lucky, patients’ results are electronically received into their electronic records and anything can be scanned into patients notes for future reference or records which saves a lot of time for the GP.

The host GP works longer hours than many GP’s in the UK. They see the same number of patients on average as they have longer consultation times. The host GP practice do not yet partake in email or telephone consultants regularly as we now do
in London. This is something that the host GP is starting to do but it is in his own time and not all the GP’s are doing this.

The host GP works closely with the practice nurses. The practice nurse’s role in Portugal differs from that in the UK. The nurse would see the patient prior to the GP and they would do basic observations and give lifestyle advice. In the UK nurse independently see patients and manage chronic diseases.

Portuguese GP’s and nurses in the GP practice play a large role in child health surveillance and antenatal care. GP’s see children frequently up to age 2 and then every year up until 5 years of age and then less frequently up to the age of 16. Similarly, they see pregnant patients monthly. In the UK midwives and health visitors who are established to do these roles. In the host GP practice, they have no equivalent for the roles of health care professionals in primary care such as pharmacist, health care assistants, midwives, health visitors.

GPs in Portugal play a big part of chronic disease management, this differs from the UK.

In the UK a large proportion of chronic diseases are managed by practice nurses and in-practice pharmacist and community services. Eg. Heart failure team, community diabetes team. GPs in Portugal are responsible for arranging breast, cervical and colorectal cancer screening. Portugal does not have national screening programmes for these conditions, so GP’s are responsible for organising the screening tests and following up the results. This differs largely from the UK where national screening is offered for this and the GPs role is to encourage and inform patients about the screening.

Table 1. Positives and negatives identified during exchange.

<table>
<thead>
<tr>
<th>Positive aspects of primary care in Lisbon</th>
<th>Negative aspects of primary care in Lisbon</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Continuity of care</td>
<td>✗ Nurses are unable to perform smears</td>
</tr>
<tr>
<td>✔ Easy access referral system similar to NHS ERS</td>
<td>✗ no formal sexual health services in the community</td>
</tr>
<tr>
<td>✔ Access to hospital notes nation-wide</td>
<td>✗ GP’s have to input individual results which is time consuming and affects the consultations</td>
</tr>
<tr>
<td>✔ GP’s have 20 minute appointments</td>
<td>✗ No confidential waste bins</td>
</tr>
</tbody>
</table>
| ✔ suitable examination beds to assist with gynaecology examinations and immunisations | ✗ No control over the equipment available in the practice  
  Eg. Lack of equipment to insert IUD’s and therefore patients would have to wait |
| ✔ When suspecting cancer diagnosis, the GP organises the tests and arranges follow up with the right service. Patients can get their initial diagnostic investigations and appointments with the specialist consultant within 2 weeks | ✗ No national screening programmes eg. Breast, cervical and colorectal cancers |
| ✔ A fully established service implemented similar to the UK NHS 111 | ✗ Limited access to telephone interpreter services |
Take home message
This was an invigorating experience. Spending time with an enthusiastic GP reminded me of why I chose the profession in the first place. In the current climate of health care, it is important to share experience and learn from our colleagues around the world.
Key aspects I think we can learn from this exchange is continuity of care with our patients. Also taking an active interest in public health. More emphasis should be placed on promoting projects in relation to social prescribing.