

Tales of two European cities: primary care in *actualité*

Francesco Carelli
Milan

John Spicer
London

Abstract:

Comparisons between primary care settings in Europe are of particular moment since the RCGP adopted EURACT criteria in the new MRCGP curriculum. This article contrasts 2 everyday GP experiences between Italy and England. Themes of practice are shown to be common but systemic differences are evident and prevail. The reader is encouraged to reflect on these two aspects in the course of the article

Why this matters to London:

Milan and London are among the big cities of the new Europe. We might assume that primary care is very different in each city, but it is not. Profound change approaches the NHS with ever increasing speed, and by looking at other systems we can seek to adopt what is good and leave aside what is not. However GPs in both countries maintain ancient and crucial approaches to practice. This must be valued and preserved.

I Milan

It is raining.

This is good news if I think of our plain, which is now a little arid. But it is bad news if I think of the home visits that await me. I travel around Milan by scooter: it is a fast vehicle, but I have to pay attention to the traffic and with wet streets the risk is greater.

At 8 o'clock in the morning I go down to my surgery, and wait for phone calls. My old woman has got a cough. She seems to be tough and makes light of her troubles, but she still feels the weight of her 96 years. She has already seen her husband die, who also was a patient of mine from a few months after I had opened my surgery. After that also her son died. He first had a kidney tumour and then a devastating prostate cancer. It took only a few months, and then his mother was left crying. But now it seems that the widow is suffering a little less.

Today I have got only one home visit: the threat of making patients pay if a home visit is not clinically justified is useful. Actually not to reduce the number of home visits (when they call me, I usually go in the end), but it does give me an opportunity to maintain some dignity, to make me feel as a doctor, not just an errand-boy, filling useless forms and writing strange and hair-splitting summaries.

Correspondence to:
Professor Francesco Carelli
francesco.carelli@alice.it

These are all ways of supplementing my salary. Yes, because I only get partly paid for my work. I do not get paid for the clinical excellence (allow me a bit of pride), but for participating in a Local Health Authority research project, trial or experiment, for buying a mobile phone dedicated to my patients (who often do not use it), for spending a couple of evenings listening lazily to some specialists getting upset while pretending to communicate scientific data.

Like the one (actually, he is not a specialist, but an LHA executive) who first convinced us about the benefits of eating squirrel's quantities of walnut kernels to reduce the cholesterol (actually it works, but with doses which dangerously increase the waist measurement), and then tried to explain us that clorthalidone is a useful – if not essential or even unique - drug for treating all cases of high-blood pressure. When I then looked at the scientific data he mentioned, I discovered that they were based on a study on African Americans, who are few and far between in our country.

Finally, he is now trying to convince us that the use of generic drugs saves public money. Too bad that the difference between a generic and a branded drug is charged to the patient; but maybe nobody has told him.

Later in the morning, I have been summoned to the LHA Central Department. They have discovered that I'm a low prescriber, i.e. I spend much less than of the average on the patients. There are two possibilities: either I prescribe better, or I have a really high mortality in my district. Either way, I have been convened together with the other bad prescribers. I spend a couple of hours listening to how and why we should save money (and I ask myself if I should spend even less), but I give up and leave when 2 colleagues with a bossy attitude start to explain to the others how they should behave. Disgusted, I get back on my scooter and set off to finish my visits.

So I drive round my Milan: from via Montenapoleone I go down towards Piazza della Scala, and I see a local police officer at a crossroad, trying in the traffic to calm the yet another lady driver caught talking on her mobile phone: "...But it was just for a moment, I was talking to my...er...boyfriend".

Just after setting off, I see out of the corner of my eye a vaguely soviet-style-building called "House of Health". A group of doctors there profit from regional incentives by pretending to treat patients better. A few specialists, an instrument for measuring cholesterol and blood count, and a nurse filling in prescriptions together convince (not the patients but the wise politicians of the Regional Council) that they are providing advanced primary care. The quality of the service is of course an optional extra, but, get away... The rooms have been provided almost for free by the pharmacy located at the entrance (are there any ethic problems? It is better not to ask it for the moment). The pharmacy also pays the cleaners, the nurse, a secretary, while the doctors come and go as they please.

The relationship of trust – the one that should tie up patients to the doctor they have selected – has been found in the yard between the boxes of sorted waste awaiting collection (also paid by the pharmacy). But it is ok: this is the way the health service is going. No longer professionals, building a reputation on the basis of their ability to cure, but "Houses of the people" or, even better, "Houses where health is administered". And it seems that at the entrance the secretary also shows patients a book illustrating the quality and services offered by the doctors who are there, so that they have a free and informed choice. I don't know why, but actually it reminds me of some times long gone and other "houses". It is a fact that doctors have become ...

No! I still do not to agree. I understand that such services are needed in the provinces, so that patients can at least find some essential services without having to travel many kilometres to reach the closest surgery. But why here, in Milan, where there are six or seven excellent hospitals? I cannot find the answer by looking at the doubtful faces entering the "House of Health" and it is difficult to spot a glimmer of conviction in the expressions of the regional executives, the LHA managers, the new bosses. Do you know the joke about the bosses? It comes to my mind as my scooter speeds past a long line of cars, but I cannot write it down now because I would get a summons at least.

I stop for lunch. Not a sandwich, just a quick artichokes salad, in order to continue my diet. I'm about to put in a handful of nuts, but my waistline

protests, so I give up. And the calculation of the cardiovascular risk? I should know it, but I avoid the issue again.

In the afternoon I read the news about the renewal of the contract. I am astonished to read that there is no money to raise doctors' pay, and any increases will be less than the inflation of the last four years. On the other hand, there is money for every other group that protests. But we doctors, we never strike (that would harm our patients). The threat of a wildcat strike is a rite which is always repeated at the start of negotiations (though nobody believes it anymore), but it is immediately rejected, as the union does not dare make absurd requests. In any case there is no money, and the trade unionists will get their slice of cake which will be big, very big or huge.

Sadly, I look to my bank account. The internet allows me to do this, so that I can admire the figures in red. I think about my rent, which increases every year (due to inflation). I sum up the bills from the laundry and for the petrol which is devoured by my old Opel. I think, I will never manage to find the money to change it, and I have to hope that the Anglo-German technology will make it last for a long time yet.

Then I start with the surgery. And I begin again to feel like the boy who many and many years ago still believed in medicine, in treating people, in being able to perform diagnoses on the sole basis of a precise anamnesis, a careful examination and few laboratory tests.

I always warn trainees and students working with me that out of a hundred patients there will be at least two (statistically) serious case. It's up to the doctor to find them, to let the patient talk and then to examine him or her. In this case I am still satisfied, I feel like a senior consultant, even if only to myself. Actually I feel a little alone, but I am consoled by the words of a really nice girl who says I saved her mother's life by sending her to hospital. Maybe she is exaggerating a little, but I have learned not to contradict patients, especially when they are so enthusiastic. It was a strange case. Her mother had an atypical precordial pain, but I decided to do an ECG right away. Because of the anomalies, I consulted a friend of mine, a cardiologist, who confirmed that I should quickly have her

heart enzymes measured.

So they caught her just before the heart attack. With a stent they reopened her circumflex artery and now she is back at home, cooking pumpkin tortelli. She said she would send me some.

After a couple of hours, I start feeling tired (alas, I can no longer cope with the usual 14-hour working day). I feel sorry for the Ugandan woman who would like to abort in the seventh month of pregnancy, so I send her to the "Help for Life Centre". After a series of prescription renewals, sick notes (there is a lot of flu this year) and phone calls from someone who has got a really terrible pain in his right foot perhaps because I played tennis for three hours yesterday (I envy him so much!), I see the last patient leave, a lady who came as usual with her husband's test results.

At home my wife maybe feels that I'm a little distracted and tired (how long is since we last made love?), but my sons manage to tell me, even if I don't know why, that they are proud of their father.

In fact I don't know what to hope for any more. To retire soon or to go on to the last?

I still think about the young doctor who told me, when I was at secondary school, that "medicine is the most humanistic profession". He was right. Maybe that is what has kept me going till now, and will continue to do so, for as long as I will believe in the personal relationship between doctor and his patient (I'm really thankful to Balint and his brilliant intuitions), which not even the LHA can destroy, also if it's trying to.

I too will try, once again, to continue.....

II London

And so will I, in the perhaps meaner streets of South London. Where they are named *Via Montenapoleone* I might more happily cruise them to do my home visits. *High Street* just won't do.

My day starts, as do most London GPs, with the attempts to remember the many log ons that I need to do my work. It worries me that my interactions with my patients and colleagues are filtered through electronic media, and there are advantages quite clearly, to this arrangement, but nonetheless I am reminded of its artificiality.

Connected to the 'world', I begin a three or four hour clinical session, often accompanied by a student of health care practice. Sometimes, while recovering afterwards, I continue to be struck by the richness of the work I do. For whatever reason, the people who come to see me show a trust in my alleged knowledge and skills which never ceases to amaze, even after 25 years in the same seat.

I see old and young, simple and complex, medical and non medical, connected and unconnected.

I try to reduce complicated notions of personal health risk to intelligible general terms. On one day my first patient was unclear about just what having a 10-20% risk of cardiovascular disease in the next ten years meant: this involved, as it necessarily would, a long interpretation of the New Zealand tables with his personal story of a cardiac event.

A similar conversation in the cardiac clinic had not cut the mustard, it seemed, and as so often was the case, primary care had to sort out the communications.

My schedule was blown out of the water by this consultation and so many others during the course of the morning. How wonderful it would be to have an adequate time frame within which to see our always complex clients.

Though no money, thankfully, changes hands at the time of the consultation, we do have an increasingly present backdrop of resource allocation to consider. Just offering my first patient more time than another

is a rationing issue, as is the nature of the statin I might offer him within that time.

In any event the parade of human suffering, mild and severe, that I am exposed to that morning runs out of steam and I move to my car to see the home visit patients.

And the first one is quite unusual, being an activity I have not done for some years.

I drive through a rough part of our community to a block of flats catering to young single vulnerable women, for a meeting with the local psychiatric team. We are a psychiatric social worker, psychiatrist, community psychiatric nurse and me; gathered to interview a young woman with alleged behaviour problems. She also had a complex endocrine history with which I was passing familiar. In fact one of my partners had more knowledge of this, so we had had something of a handover about it just before.

The session took a while to get going, in view of her erratic behaviour, and was led, for the most part, by the PSW. Times had changed since my time in psychiatry many years previously, and for the better.

It did not take much enquiry to unwrap a very paranoid, highly systematized delusional state. Not enough, at this stage, to invoke compulsory powers, but enough to prompt shared follow up and monitoring. And a clear plan for the inevitable crisis when it occurred. As we walked back to our cars, the psychiatrist and I reflected on how useful it was for primary and secondary care to work together in this way, how rarely it happened, and how we might try and do it more.

More generally, that it could and does happen is strength of our UK system. Whether current NHS changes will bring this about, or engender a spurious competition between primary and secondary care agencies is moot.

I return to the surgery to consider the various organisational problems and issues within the practice. We have a meeting of partners and managers for a couple of hours over lunch and beyond, about 8 people all told.

Among other things we are worrying about prescribing, or more correctly being told to worry about it by

virtue of some spreadsheets emanating from our primary care organizations in what seems like 4 point fonts.

A montage of incentives and disincentives all are ranged to exert pressure on our prescribing habits. These too are rationing decisions we are engaged in, though sometimes it is more implicit than otherwise. More often than not, I am content to play by these rules, believing generally in class effects in pharmacology.

If Bloggs-PPI is as effective as Snooks-PPI and half the price, who could possibly worry about switching patients over? Well, strangely enough some of our patients could, and for reasons that often seem irrational or unpredicted. Most however go with the flow, and accept the often yearly drug switches within classes, and that makes life easier. Sneakily, I admit to myself that I quite enjoy the pointed conversations about drug changes generated by PCT advice, revealing as it does negotiation, sharing of information and [mostly] agreement

Before the afternoons' business I ignore the sixty emails in my inbox, feeling guilty as they are no doubt important, and refer to the other part of my week in academia and education, but the GP day just cannot accommodate anything other than GP activity. They will have to wait until I get home.

So I drive over to the nursing home that we look after, and I have recently taken under my wing. It has a lot of highly dependent patients within it, all of whom are there because they have nursing needs to some extent. This feels like the sort of clinical care I did so long ago: checking on pressure sores, assessing cognition, watching walking and so much else. These are elderly patients with needs across many domains, and generate much careful thinking as I go round.

Nowadays that includes discussions with patients and relatives about Do Not Attempt Resuscitation documents, or what are more usefully described as Allow Natural Death documents. Here again I am minding my legal p's and q's, something which give me a personal fillip, as it conjoins clinical practice with its theoretical foundations.

After the evening surgery which follows, I drive home pretty exhausted, but with a sensation of at least having achieved.....something. At least several patients may be the better for my efforts, I have relished the trust relationship with many, and my intellect [such as it is] has been engaged all day.

Have I been suitably recompensed for my efforts? Probably not, but that has as much to do with my own aptitudes and inclinations in the generation of income.

But it's been OK.

III Conclusions

Are there any to be drawn? Probably not, probably yes.

Here are presented 2 day stories of the same job under rather different organisational milieux. The themes of practical patient care, trust relationships and financial pressure resonate through the stories as they probably have always done since GPs were brought into existence, or not, where something more dangerous is on GP's horizon?

Are these doctors OK, are they good enough? Or are they in danger of spreading perplexities and burn-out?

You decide.